

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-031745

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. \_\_\_\_\_ Registrar's No. 110

AMENDED

FILED OCT 10 1961

1. PLACE OF DEATH a. COUNTY <u>ATCHISON</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FAIRFAX</u>		Length of stay in 1b <u>2 DAYS</u>	c. CITY OR TOWN <u>CRAIG</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COMMUNITY HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY JANE ROADS</u>			4. DATE OF DEATH Month Day Year <u>OCT. 6, 1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-1892</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN THE HOME</u>		11. BIRTHPLACE (City and state or country) <u>FILLMORE, MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					

13a. FATHER'S NAME <u>JOSEPH WARDLOW</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH FRANCES LANCE</u>		14. NAME OF HUSBAND OR WIFE <u>WILBY ROADS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>WILBY ROADS, CRAIG, MO.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			<u>1 day</u>
DUE TO (b) <u>Coronary Thrombosis</u>			<u>1 day</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			<u>years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Oct 4, 1961 to Oct 6, 1961 and last saw her alive on Oct 6, 1961  
Death occurred at 2:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James Humphrey M.D.</u>	22b. ADDRESS <u>Mound City, Mo.</u>	22c. DATE SIGNED <u>10/6/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-8-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>CRAIG, MISSOURI</u>
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24. FUNERAL DIRECTOR ADDRESS <u>James H. Crawford, Mound City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 8, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Herwin J. Schaefer</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James H. Crawford  
Licensed Embalmer No. 4796  
P. O. Address Round City,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.