

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035614
STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 6179 Registrar's No. 83

AMENDED

FILED OCT 2 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Twp.</u>		Length of stay in 1b <u>4 yrs.</u>		c. CITY OR TOWN <u>Pollock</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural Route</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Ann</u> Last <u>Powell</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1961</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/19/1871</u>		9. AGE (last birthday) <u>90</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
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>Farm home</u>		11. BIRTHPLACE (City and state or country) <u>Pollock, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13a. FATHER'S NAME <u>Thomas A. Roseberry</u>				13b. MOTHER'S MAIDEN NAME <u>Martha True</u>				14. NAME OF HUSBAND OR WIFE <u>George Powell</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>Mrs. James McDonnall, DesMoines, Iowa</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ureapic poisoning</u> DUE TO (b) <u>Fractured hip</u> DUE TO (c) <u>Falling on floor</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Sensitivity - Chronic glomerulonephritis</u>								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							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>When they fractured left hip</u>											
20c. TIME OF INJURY Hour <u>9-10-61</u> Month, Day, Year p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>In bedroom at home</u>								20e. CITY, TOWN, OR LOCATION <u>Green City, Sullivan</u>		20f. COUNTY <u>Sullivan</u>		20g. STATE <u>Mo</u>	
21. I attended the deceased from <u>9-12-61</u> to <u>9-15-61</u> and last saw her alive on <u>9-13-61</u> Death occurred at <u>9:40 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								22a. SIGNATURE (Degree or title) <u>Chris L. Judd</u>		22b. ADDRESS <u>Unionville Mo</u>		22c. DATE SIGNED <u>9-13-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Scobee Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sullivan County, Mo.</u>									
24. FUNERAL DIRECTOR ADDRESS <u>Blanca E. Keaton, Green City, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-25-61</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beckett</u>									

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo.

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.