

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040310

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 271

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> Length of stay in 1b <u>4 mo.</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u> c. CITY OR TOWN <u>Fulton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>208 Oak St.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>B</u> Last <u>Dickerson</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>13,</u> Year <u>1961</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>1-1-1874</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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>same</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charlie Bartlett</u>			13b. MOTHER'S MAIDEN NAME <u>Hester Ann ??</u>		14. NAME OF HUSBAND OR WIFE <u>unk</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>			17. INFORMANT Address <u>State Hospital No. 1, Fulton, Mo.</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>Lung - pulmonary congestion and edema</u> DUE TO (b) <u>aspiration of gastric contents, bloody</u> DUE TO (c) <u>duodenum - acute peptic ulcer, bleeding</u>		INTERVAL BETWEEN ONSET AND DEATH
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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>State Hospital No. 1</u>		20f. CITY, TOWN, OR LOCATION <u>7-10-61</u>		STATE <u>11/13/61</u>	
21. X attended the deceased from _____ to _____ Death occurred at <u>8:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>Lois R. Handley MD</u>		22b. ADDRESS <u>Fulton, Mo.</u>		22c. DATE SIGNED <u>11/14/61</u>	
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE <u>Nov. 17 1961</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Southside</u>	
24. GENERAL DIRECTOR <u>George H. Green</u>		25. DATE RECD. BY LOCAL REG. <u>Nov-14-1961</u>		23d. LOCATION (City, town, or county) (State) <u>Fulton, Missouri</u>	
ADDRESS <u>Justin Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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

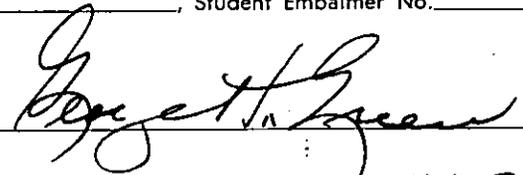
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4270

P. O. Address Tacoma, W.

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.