

# OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-042015**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 292 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

AMENDED

**FILED DEC 11 1961**

1. PLACE OF DEATH a. COUNTY <b>Ralls</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Ralls</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>	Length of stay in 1b <b>15 yrs</b>	c. CITY OR TOWN <b>Hannibal</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R # 1</b>		d. STREET ADDRESS (If outside, give location) <b>R # 1</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Dwane</b> Middle <b>Lee</b> Last <b>Fohey</b>			4. DATE OF DEATH Month <b>Nov</b> Day <b>28</b> Year <b>1961</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1939</b>	9. AGE (last birthday) <b>22</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hydro Dept</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>International Rubber Plant</b>	11. BIRTHPLACE (City and state or country) <b>Palmyra, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Jesse Fohey</b>	13b. MOTHER'S MAIDEN NAME <b>Carrie Gulick</b>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Army 1956-1959</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>Carrie Fohey</b> Address <b>Hannibal, Mo. R # 1</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning, acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10-20 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

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 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.) <b>Sleeping in room with coal stove</b>
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20c. TIME OF INJURY <b>4:30 a.m.</b>	Month, Day, Year <b>11 28 61</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. CITY, TOWN, OR LOCATION <b>2 mi South Hannibal</b>	COUNTY <b>Ralls</b>	STATE <b>Mo</b>
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **9:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Henry H. Sweet Jr MD</b>	22b. ADDRESS <b>Hannibal Mo</b>	22c. DATE SIGNED <b>11/30/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec 1, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Cemetery</b>	23d. LOCATION (City, town, or county) <b>Hannibal, Mo.</b> (State)
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24. FUNERAL DIRECTOR ADDRESS <b>Clark Funeral Home - Hannibal, Mo.</b>	25. DATE HELD BY LOCAL REG. <b>12/7/1961</b>	26. REGISTRAR'S SIGNATURE <b>Clyde Wilkey</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ.

DEC 14 1961

JAN 30 1962

JAN 10 1962

**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 *Ralph J. Clark*

Licensed Embalmer No. 4217

P. O. Address Hannibal, 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.