

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044063

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 098 Primary Registration District No. \_\_\_\_\_ Registrar's No. 19

AMENDED

**FILED DEC 26 1961**

1. PLACE OF DEATH a. COUNTY <u>Davies</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Davies</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Barton Twp.</u>		c. CITY OR TOWN <u>Pattonburg</u>	
Length of stay in lb <u>15yr.</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		d. STREET ADDRESS (If outside, give location) <u>Barton Twp.</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Foreman</u> Last _____			4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>EW</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>11-14-1922</u>
9. AGE (last birthday) <u>79</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>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Harrison Co Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>unk.</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Beunin</u>		14. NAME OF HUSBAND OR WIFE <u>Andrew Foreman</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>unk.</u>	17. INFORMANT <u>Andrew Foreman</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>Cardio-Respiratory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombo-embolism</u>		<u>immed</u>	
DUE TO (c) _____		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 checked="" 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 _____
21. I attended the deceased from <u>12-15-1961</u> to <u>12-15-1961</u> and last saw her alive on <u>12-15-61</u> Death occurred at <u>8:50</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. Lane Howell</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Pattonburg, Mo.</u>	22c. DATE SIGNED <u>12-16-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>12-18-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>	23d. LOCATION (City, town or county) (State) <u>Pattonburg Mo.</u>
24. FUNERAL DIRECTOR <u>Roberson Chapel</u>	ADDRESS <u>Pattonburg Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>22 Dec '1961</u>	26. REGISTRAR'S SIGNATURE <u>Urgie Wengelhart</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JAN 17 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 H.A. Johnson

Licensed Embalmer No. 5975

P. O. Address St. Louis, 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.