

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006124

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 120 Primary Registration District No. _____ Registrar's No. 23

FILED FEB 27 1962

1. PLACE OF DEATH a. COUNTY <u>Gentry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Albany</u>			Length of stay in 1b <u>14 hrs.</u>		c. CITY OR TOWN <u>Worth</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>Gentry Co. Mem. Hospital</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 <u>Alice</u> Middle <u>M.</u> Last <u>Foland</u>			4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1962</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>11-20-1889</u>	9. AGE (last birthday) <u>72</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>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
13a. FATHER'S NAME <u>Freemont Trump</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Miller</u>			14. NAME OF HUSBAND OR WIFE <u>Commodore C. Foland</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. [REDACTED]		17. INFORMANT Address <u>Harold Foland - Grant City, Missouri</u>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MEDULLARY FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>GANGRENUX ABSTRACTED COLON & INTESTINE</u> <u>2 DAYS</u>	
						DUE TO (c) <u>EXTENSION OF CARCINOMA OF LEFT ADNEXA</u> <u>2 TO 12 MONTHS</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		
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
21. I attended the deceased from <u>1958</u> , to <u>FEB 16, 1962</u> and last saw her <u>alive</u> on <u>FEB 16, 1962</u> Death occurred at <u>1:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Richard L. Swift D.O.</u>				22b. ADDRESS <u>GRANT CITY Mo.</u>		22c. DATE SIGNED <u>2-17-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Feb. 18, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grant City Cemetery</u>		23d. LOCATION (City, town, or county) <u>Grant City, Missouri</u>		
24. FUNERAL DIRECTOR <u>Bill A. Dunfee, - Grant City, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>2-19-62</u>		26. REGISTRAR'S SIGNATURE <u>Wm. L. W. Bare</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address Grant 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.