

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024904

FILED VS AUG 1 0 1959 37

Primary Registration District No. _____ Registrar's No. 196

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Henry</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Henry</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Windsor</i>		Length of stay in 1b <i>2 weeks</i>		c. CITY OR TOWN <i>Calhoun</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Windsor Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>R.F.D. 2</i>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>MINNIE</i> Middle <i>McCLUNG</i> Last <i>CHANEY</i>				4. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 12, 1876</i>	9. AGE (last birthday) <i>83</i>	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) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Benton County Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13a. FATHER'S NAME <i>Addison McClung</i>			13b. MOTHER'S MAIDEN NAME <i>Annie Mc Intire</i>		14. NAME OF HUSBAND OR WIFE <i>Lester Chaney</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Lester Chaney Calhoun Mo. RFD. 2</i>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Collapse</i> DUE TO (b) <i>Metastatic Infiltration</i> DUE TO (c) <i>Carcinoma of the uterus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Extreme Malnutrition & Dehydration</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i> <i>years</i> <i>years</i>
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 <i>18 June 59</i> to <i>31 July 59</i> and last saw her/him alive on <i>31 July 59</i> Death occurred at <i>1140 Hrs</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Gordon Wm. Ruffel M.D.</i> (Degree or title)				22b. ADDRESS <i>Windsor, MO</i>		22c. DATE SIGNED <i>4 Aug 59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Aug 2, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Laurel Oak</i>		23d. LOCATION (City, town, or county) <i>Windsor</i> (State) <i>Mo.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Ellis M. Houston Windsor Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>8-5-59</i>		26. REGISTRAR'S SIGNATURE <i>Mildred Bigan</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6981 6 7 907
AUG 19 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm L. Downing

Licensed Embalmer No. 5067

P. O. Address Windsor M

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.