

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015026

FILED VS MAY 2 1960

137

3023

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STATE FILE NUMBER

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Henry</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clinton</b> Length of stay in 1b <b>10 days</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Wetzel Hosp</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>Henry</b> c. CITY OR TOWN <b>Brownington</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>R R # "2"</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Elmer</b> Middle <b>Jessie</b> Last <b>Gregory</b>			<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>21</b> Year <b>1960</b>				
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-14-1893</b>	<b>9. AGE (last birthday)</b> <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Audrain Co Mo</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>John H Gregory</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ida Gregory</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>490-42-8843</b>		<b>17. INFORMANT</b> <b>Ida Gregory</b> Address <b>Brownington Mo</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute circulatory failure</b> DUE TO (b) <b>myocardial insufficiency</b> DUE TO (c) <b>prostatic hypertrophy - operated</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute cholecystitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>2 days.</b> <b>2 years.</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY STATE</b>			
<b>21. I attended the deceased from</b> <b>April 16, '60</b> to <b>April 21, '60</b> and last saw him alive on <b>April 21, 1960.</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Carroll F. Wetzel, M.D.</b>				<b>22b. ADDRESS</b> <b>Clinton Mo</b>		<b>22c. DATE SIGNED</b> <b>4-22-60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>4-22-60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT ZION</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Mt Zion Henry Co. Mo</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Sickman &amp; Dunning Clinton Mo</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>April 25, 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Waldred Bigum</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 R. L. Dunning

Licensed Embalmer No. 4716

P. O. Address Clinton

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.