

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040827

FILED VS NOV 9 1960

360 Primary Registration District No. 6225 Registrar's No. 225

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in 1b <u>1y 5mo 1d</u>		c. CITY OR TOWN <u>Clinton</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>Mo. State Hosp #3 Nevada, Mo</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>unk</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>L.</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>60</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>w</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>10-26-75</u>	9. AGE (last birthday) <u>85</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>unk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (City and state or country) <u>Henry Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>unk</u>			13b. MOTHER'S MAIDEN NAME <u>unk</u>			14. NAME OF HUSBAND OR WIFE <u>unk</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>			16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Records State Hosp #3 Nevada Mo</u> Address			
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>Atherosclerotic Cardiovascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
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) <u>Chr. Brain Syndrome associated with Cerebral Arteriosclerosis</u>						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		
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 Month, Day, Year s.m. p.m.								
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>7-9-59</u> to <u>11-2-60</u> and last saw ^{her} him alive on <u>8-2-60</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>Nevada Missouri</u>			22c. DATE SIGNED <u>11/2/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov 3, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clinton Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clinton Missouri</u>			(State)
24. FUNERAL DIRECTOR <u>Consalus Funeral Home</u> <u>Clinton Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>11 4 - 60</u>		26. REGISTRAR'S SIGNATURE <u>Arnold E. F...</u>		

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

Jerry F. Milster

Licensed Embalmer No.

4805

P. O. Address

Nevada, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.