

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026083

FILED VS AUG 5 1959

Registration District No. 254 Primary Registration District No. 5860 Registrar's No. 29

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Oregon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Oregon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koshkonong Big Apple Twp. Rt. 2</u>		Length of stay in 1b <u>59 years</u>		c. CITY OR TOWN <u>Koshkonong Rt. 2</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			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hayden</u> Middle <u>E.</u> Last <u>Gregory</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>11/18/1899</u>	9. AGE (last birthday) <u>59</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>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ralience Mfg. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Thayer, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Gregory</u>		13b. MOTHER'S MAIDEN NAME <u>Jannie Harris</u>		14. NAME OF HUSBAND OR WIFE <u>Fay Gregory</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>495-30-1835</u>		17. INFORMANT <u>Fay Gregory</u> Address <u>Koshkonong, Mo. Rt. 2</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>Adenocarcinoma Colon</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Metastasis</u> DUE TO (c) _____ 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 type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
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>Sept 19 57</u> to <u>July 1959</u> and last saw her alive on <u>July 24, 1959</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John E. Little MD</u> (Degree or title)				22b. ADDRESS <u>Warrmoth Spring, Ark</u>		22c. DATE SIGNED <u>7-27-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/27/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Thayer</u>		23d. LOCATION (City, town, or county) (State) <u>Thayer, Missouri</u>			
24. FUNERAL DIRECTOR <u>Frank Carter</u> ADDRESS <u>West Plains Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-27-59</u>		26. REGISTRAR'S SIGNATURE <u>Arthur Wolf</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 18 1960

VS OCT 25 1960

VS OCT 25 1960

STATEMENT BY LICENSED EMBALMER

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leanne Carter

Licensed Embalmer No. 4576

P. O. Address Miss Olan

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.