

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

'59 0 4 3 6 5 9

STATE FILE NUMBER

Registration District No. 70 Primary Registration District No. _____ Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Clark</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN _____ Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Highway</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clark</u> c. CITY OR TOWN <u>Farmington, Ia.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Albert Elder</u>			4. DATE OF DEATH Month Day Year <u>Dec. 24-1959</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>May 17-1934</u>	9. AGE (last birthday) <u>23</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ben Elder</u>		13b. MOTHER'S MAIDEN NAME <u>Iva Bretz</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Elder</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>500-36-3608</u>		17. INFORMANT Address <u>Margaret Elder - Farmington, Ia.</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>Trauma from automobile accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>(over) multiple fractures</u> DUE TO (c) <u>multiple lacerations</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 type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH _____
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 _____ min. _____ Month, Day, Year <u>4:10 p.m. 12-24-59</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1.3 miles S. Wayford, Mo. on Rt 26</u>	20f. CITY, TOWN, OR LOCATION <u>Clark</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 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>Dr. Channing Du Coron</u>	22b. ADDRESS <u>Kahoka Mo</u>	22c. DATE SIGNED <u>12-31-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Dec. 27-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chamberburg Co., Clark</u>	23d. LOCATION (City, town, or county) (State) <u>Clark Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Alvin L. Letting - Kahoka Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-5-60</u>	26. REGISTRAR'S SIGNATURE <u>J. R. Driscoll</u>
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(Licensed Embalmer's Statement on Reverse Side)

AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

Car struck Bridge on wrong side of road going West
Route 26--1.3 miles East of Wayland Mo.

Multiple Fractures & lacerations:

- Broken leg left
- Broken left arm
- Broken neck
- Broken left side jaw-
- Crushed mouth & pallet
- Skull Injury
- Crushed Chest

MS
SEP 14 1960

JAN 28 1960

Lacerations on legs & back. numerous

1st car on scene of accident was John Cannon
 2d " " " " " " " " Miss Betty Hickey Corum
 " " " " " " " " Kanna Mo

STATEMENT BY LICENSED EMBALMER

MAR 22 1960

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

Arthur L. Lettney

Licensed Embalmer No. 2965

P. O. Address Wayland Mo

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.