

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000233

FILED VS FEB 15 1960 38

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 81

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>	Length of stay in 1b <u>14 Days</u>	c. CITY OR TOWN <u>Lexington</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>Univ. of Mo. Medical Center</u>		d. STREET ADDRESS (If outside, give location) <u>S. 27</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>B</u> Last <u>Thomas</u>			4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>8-18-77</u>	9. AGE (last birthday) <u>82</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>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>James Beard</u>		13b. MOTHER'S MAIDEN NAME <u>Almeta?</u>		14. NAME OF HUSBAND OR WIFE <u>Zach Thomas</u>		
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 <u>Hospital Chart Columbia, Mo</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>		<u>Oct 1959</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MYOCARDIAL INFARCTION</u>	<u>To</u>
	DUE TO (c) <u>ATHEROSCLEROSIS</u>	<u>Feb 9 1960</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>Jan. 26, 1960</u> <u>Feb 9</u> and last saw her <sup>him</sup> alive on <u>Feb 9, 1960</u> Death occurred at <u>6:20</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Michael J. Avician MD</u>		22b. ADDRESS <u>U. of Mo. Medical Center</u>	22c. DATE SIGNED <u>Feb 10, 1960</u>
23a. BURIAL, CREMATION, or REMOVAL (Specify)	23b. DATE <u>2-10-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lexington</u>	23d. LOCATION (City, town, or county) (State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>Herbert Funeral &amp; Service Columbia, Mo</u>	25. DATE RECD. BY LOCAL REG <u>Feb 10, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Miss R.E. Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Charles L. Learning

Licensed Embalmer No. 4132

P. O. Address Columbus

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.