

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960 140

=60-001292  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3024 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette</b>			Length of stay in 1b <b>52 years</b>		c. CITY OR TOWN <b>Fayette</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lee Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>West Morrison</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Tillie</b> Middle <b>Woods</b> Last <b>FRAY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1868</b>	9. AGE (last birthday) <b>91</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (City and state or country) <b>Howard County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John A. Woods</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Jane McCrary</b>		14. NAME OF HUSBAND OR WIFE <b>John William Fray</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Thomas W. Snoddy Independence, Mo.</b> 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) <b>Acute Pulmonary Edema</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiac Decompensation</b>						<b>1 wk</b>	
DUE TO (c) <b>Myocarditis</b>						<b>5 yrs</b>	
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		
19. WAS AUTOPSY PERFORMED? YES <input 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 <b>1-5-60</b> to <b>1-6-60</b> and last saw her alive on <b>1-6-60</b> Death occurred at <b>Fayette Mo - 3 mi</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>W. Bloom S.D.</b> (Degree or title)				22b. ADDRESS <b>Fayette Mo</b>		22c. DATE SIGNED <b>1-9-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 8, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fayette City Cem.</b>		23d. LOCATION (City, town, or county) <b>Fayette, Missouri</b>		
24. FUNERAL DIRECTOR <b>Markland - Hall New Franklin, Mo.</b> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <b>1-9-60</b>		26. REGISTRAR'S SIGNATURE <b>Katherine Welch</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

*Tom D. Markland*

Licensed Embalmer No. 4592

P. O. Address New Franklin

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.