

RI' DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002608

FILED VS FEB 2 1960

236

Primary Registration District No. 4352

Registrar's No. 3

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Morgan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Morgan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Versailles</b>	Length of stay in 1b <b>2 weeks</b>	c. CITY OR TOWN <b>Versailles</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>Kidwell Rest Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>W. Newton</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Mary</b> Last <b>Muir</b>	4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> Year <b>1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-1866</b>	9. AGE (last birthday) <b>93</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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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	11. BIRTHPLACE (City and state or country) <b>Cole Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William W. Simpson</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Henley</b>	14. NAME OF HUSBAND OR WIFE <b>James Muir</b>
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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>Miss Ida Simpson Olean, Mo.</b>	Address
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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)	<b>Bilateral Bronchopneumonia</b>	<b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Carcinoma of Stomach</b>	<b>6 months</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)	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
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from **1-26-60**, to **1-26-60** and last saw <sup>her</sup> ~~him~~ alive on **1-26-60**  
Death occurred at **4 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Ray Fyle, M.D.</b> (Degree or title)	22b. ADDRESS <b>Versailles, Mo.</b>	22c. DATE SIGNED <b>1-27-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>28 Jan. 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Versailles Cemetery</b>	23d. LOCATION (City, town, or county) <b>Versailles, Mo.</b> (State)
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24. FUNERAL DIRECTOR <b>Kidwell Funeral Home Versailles, Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1-28-60</b>	26. REGISTRAR'S SIGNATURE <b>J L Walsh</b>
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(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 Raymond C. Foster

Licensed Embalmer No. 4626

P. O. Address Verona, N.J.

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.