

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002920

FILED VS FEB 1 1960 294

Registration District No. _____ Primary Registration District No. 3056 Registrar's No. 17

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Moberly</u> Length of stay in lb <u>1 week</u>		c. CITY OR TOWN <u>Armstrong</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital) give location HOSPITAL OR INSTITUTION <u>Woodland Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>503 Glasgow</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>JOE</u> Last <u>ESPENSCHIED</u>			4. DATE OF DEATH <u>January-21-1960</u> Month <u>January</u> Day <u>21</u> Year <u>1960</u>		
5. SEX <u>Female</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>Mar-7-40</u>	9. AGE (last birthday) <u>19</u> IF UNDER 1 YEAR IF UNDER 24 HR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state of country) <u>Cairo Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Ralph Powers</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann Lucas</u>	14. NAME OF HUSBAND OR WIFE <u>Roger D. Espenschied</u>
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17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>497-48-1882</u>	17. INFORMANT <u>Roger Dean Espenschied</u> Address <u>Armstrong Mo</u>
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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: IMMEDIATE CAUSE (a) <u>Undiagnosed illness manifested by fever, myalgia, intrauterine death of baby at term</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
DUE TO (b) <u>(BLOOD AND SPINAL FLUID SPECIMEN SENT TO STATE LABORATORY FOR VIRUS STUDIES)</u>		
DUE TO (c) <u>—</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Term Stillborn BIRTH ANTE PARTUM DEATH JAN 19, 60</u>	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
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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.)
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> Month, Day, Year <u>—</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.)
20f. CITY, TOWN, OR LOCATION		COUNTY STATE

21. I attended the deceased from Jan 16 1960 to Jan 21 1960 and last saw her him alive on Jan 21 60
Death occurred at 4:40 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Clarence Clohrs MD</u> (Degree or title)	22b. ADDRESS <u>317 Virginia, Moberly, Mo</u>	22c. DATE SIGNED <u>Jan 22 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Gardens</u>	23d. LOCATION (City, town, or county) <u>Moberly Missouri</u> (State)
FUNERAL DIRECTOR <u>Cater Funeral Home Moberly Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-23-60</u>	26. REGISTRAR'S SIGNATURE <u>Clarence Clohrs</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 4 1960

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 R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Moberly

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.