

UNRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-005112

FILED VS FEB 29 1960 38

Registration District No. 3006 Primary Registration District No. 3006 Registrar's No. 105

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>10 Years</b>		c. CITY OR TOWN <b>Columbia</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>Boone County Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Ashland Gravel Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>GRACE</b> Last <b>CAPEN</b>				4. DATE OF DEATH <b>Feb. 19, 1960</b> Month <b>Feb.</b> Day <b>19</b> Year <b>1960</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</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>3-11-1882</b>		9. AGE (last birthday) <b>77</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Sedalia, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Arthur W. Brown</b>				13b. MOTHER'S MAIDEN NAME <b>Lydia Rogers</b>				14. NAME OF HUSBAND OR WIFE <b>James A. Capen</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>-</b>		17. INFORMANT Address <b>James J. Capen, Columbia, Mo.</b>							
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>INTRACEREBRAL Hemorrhage</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 Hours</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular disease</b>										<b>years</b>			
DUE TO (c) <b>Diabetes Mellitus</b>										<b>years</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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 <b>2:50 PM</b> 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>1956</b> to <b>19 Feb 60</b> and last saw her alive on <b>19 Feb 60</b> Death occurred at <b>2:50 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>James J. Capen MD</i> (Degree or title)						22b. ADDRESS <b>299 Univ Ave Columbia Mo</b>				22c. DATE SIGNED <b>19 Feb 60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-20-1960</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Parker Funeral Service, Columbia, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Feb 20 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</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 J. W. Phillips

Licensed Embalmer No. 4897

P. O. Address Columbus

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.