

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005553

FILED VS FEB 17 1960

Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 30 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LIBERTY</u>		Length of stay in 1b <u>3 YEARS</u>	c. CITY OR TOWN <u>LIBERTY</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>R. RT 1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. RT 1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>LOLA</u> Last <u>FISK</u>			4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>60</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>6-11-1912</u>	9. AGE (last birthday) <u>47</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>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>HANNIBAL, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>JAMES MONTGOMERY</u>		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <u>George R. Fisk</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>498-30-5423</u>	17. INFORMANT <u>George R. Fisk</u>	Address <u>RT 1 LIBERTY, 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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>left CORONARY ARTERY Occlusion</u>		<u>Minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CORONARY ARTERY DISEASE</u>	<u>YEARS</u>
	DUE TO (c) <u>Hypo Pituitary OBESITY</u>	<u>Life</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Duodenal hemorrhage</u>		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 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
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21. I attended the deceased from 8 Feb 1960 to 9 Feb 1960 and last saw her alive on 8 Feb 1960
Death occurred at 6⁰⁰ A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W J Barnes MD</u>	22b. ADDRESS <u>2014 Swift NKC Mo</u>	22c. DATE SIGNED <u>9 Feb 1960</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomer's Son</u>		23d. LOCATION (City, town, or county) (State) <u>Kearney, Mo.</u>

24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomer's Son N.K.C.</u>	25. DATE RECD. BY LOCAL REG. <u>2-11-60</u>	26. REGISTRAR'S SIGNATURE <u>Marquette Judgens</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF:

1961 9

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 *Glenn J. Hill*

Licensed Embalmer No. 4586

P. O. Address K.C. 18.2

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.