URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 24 1960

NDED

Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 7

-60-007399
STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: Newton
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Stella
Length of stay in 1b: 1 week
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Cardwell Memorial
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: McDonald
c. CITY OR TOWN: Anderson
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): None
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: JESSIE Middle: GRACE Last: CLINE

4. DATE OF DEATH Month Day Year: Jan. 14, 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 1-8-1884

9. AGE (last birthday): 76

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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (City and state or country): Unknown

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 491-16-5650

17. INFORMANT: Mrs. Joe Queen Address: Anderson, Mo.

MEDICAL CERTIFICATION

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)	Medullary Failure	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral Ischemia	36 hrs
DUE TO (c)	Cardiac Decompensation	48 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Trauma of (attempted) Vaginal Hysterectomy

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1-11-60, to 1-14-60 and last saw her alive on 1-14-60

Death occurred at 6:35 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): CR Holman D.O.

22b. ADDRESS: Stella, Mo.

22c. DATE SIGNED: 1-23-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Jan. 17, 1960

23c. NAME OF CEMETERY OR CREMATORY: Anderson

23d. LOCATION (City, town, or county) (State): Anderson, Mo.

24. FUNERAL DIRECTOR ADDRESS: Roller Funeral Home Anderson, Mo.

25. DATE RECD. BY LOCAL REG.: 1-27-60

26. REGISTRAR'S SIGNATURE: Mildred Moberly

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Robert C. Roller

Signature of Student Embalmer

Licensed Embalmer No. 5062

P. O. Address Anderson, T

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