

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009644

FILED VS MAR 1 1960

360

Registration District No. _____ Primary Registration District No. 6225 Registrar's No. 34

STATE FILE NUMBER

IDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Vernon</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Lawrence</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		Length of stay in lb <u>20 yrs. 5 mos.</u>		c. CITY OR TOWN <u>Aurora</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>State Hospital #3</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Ray</u>		Middle <u>Bethel</u>		Last <u>Denney</u>		Month Day Year <u>Feb. 13 1960</u>	
5. SEX <u>Male</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>6-8-1907</u>	9. AGE (last birthday) <u>52 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coca Cola Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Aurora, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Eli Denney</u>			13b. MOTHER'S MAIDEN NAME <u>Ollie Browning</u>			14. NAME OF HUSBAND OR WIFE <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Hospital Records State Hospital #3</u>			
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>Pneumonia - Lobar</u>							
DUE TO (b)							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (c) <u>Syphilitic Meningoencephalitis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychosis</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	
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 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	
21. I attended the deceased from <u>March 1, 1956</u> to <u>Feb. 13, 1960</u> and last saw <u>him</u> alive on <u>Feb. 13, 1960</u> Death occurred at <u>5:45</u> a <u>m</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W.C. Bradley MD</u>				22b. ADDRESS <u>State Hospital #3, Nevada, Mo.</u>		22c. DATE SIGNED <u>2-13-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-15-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Local Aurora Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Aurora, Missouri.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Ferry Funeral Home, Nevada, Missouri.</u>				25. DATE RECD. BY LOCAL REG. <u>Feb 24-1960</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Jerry</u>	

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 *L. Douglas Ferry*

Licensed Embalmer No. 4960

P. O. Address Manada

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.