

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014030

FILED VS APR 18 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 101

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in 1b <u>5 yrs</u>		c. CITY OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Crim-Smith Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>201 E. Patterson</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mayme</u> Middle <u>Deegan</u> Last <u>Deegan</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>17 Oct 1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>Adair Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William H. Foreman</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Seward</u>			14. NAME OF HUSBAND OR WIFE <u>George W. Deegan</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> </u>		17. INFORMANT Address <u>Mrs Sarah Wimp, Kirksville, Mo</u>			
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>Coronary Occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerosis, general, degenerative type.</u>						
		DUE TO (c) <u>Aged</u>						
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 <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u>						
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>1955</u> to <u>4/6/60</u> and last saw her <u> </u> alive on <u>4/6/60</u>				Death occurred at <u>10:25</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD.</u>				22b. ADDRESS <u>Kirksville, Mo.</u>		22c. DATE SIGNED <u>4/6/60</u>		
23a. BURIAL CREATION, REMOVAL (Specify)	23b. DATE <u>4-8-1960</u>	23c. NAME OF CEMETERY <u>Highland Park</u>		23d. LOCATION (City, town, or county) <u>Kirksville</u>		STATE <u>Mo.</u>		
24. FUNERAL DIRECTOR <u>Davis & Davis, Kirksville, Mo</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-14-1960</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 2 2 NNP1

J. J. Wimer, M.D.

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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirkville,

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