

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014035

FILED VS MAY 9 1960

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 127

STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b	c. CITY OR TOWN Macon Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 604 Madison Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SHIRLEY L. FUQUA			4. DATE OF DEATH Month Day Year May 2 1960		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1884	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Butcher	10b. KIND OF BUSINESS OR INDUSTRY Food Locker	11. BIRTHPLACE (City and state or country) Redman Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Harvey Fuqua	13b. MOTHER'S MAIDEN NAME Mary E. Farmer	14. NAME OF HUSBAND OR WIFE Gertrude Olive
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 494-05-1937	17. INFORMANT Address Mrs. Gertrude Fuqua Macon, Mo.
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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: IMMEDIATE CAUSE (a) Acute Circulatory Failure		INTERVAL BETWEEN ONSET AND DEATH 18 Hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Decompensated Arteriosclerotic Heart Disease		Unknown
DUE TO (c) Generalized Arteriosclerosis and Diabetes		Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease, condition given in PART I L. CEREBRAL Thrombosis - Prostatic Hypertrophy - Cystitis		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
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. 11	Month, Day, Year 11
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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 Macon	COUNTY Macon	STATE Mo.
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21. I attended the deceased from 4-10-60 to 5-2-60 and last saw her/him alive on 5-1-60 Death occurred at 1:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Paul Laughlin J. B.	22b. ADDRESS Kirksville, Mo	22c. DATE SIGNED 5-4-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/4/1960	23c. NAME OF CEMETERY OR CREMATORY Oakwood	23d. LOCATION (City, town, or county) (State) Macon Mo.
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24. FUNERAL DIRECTOR ADDRESS R. Lester Bream Macon, Mo.	25. DATE RECD. BY LOCAL REG. 5-5-1960	26. REGISTRAR'S SIGNATURE Doris W. Rathff
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EARL HAUGHLIN, JR. D.O.

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 R. L. B. B. B.

Licensed Embalmer No. 4472
P. O. Address Mason, Va.

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