

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016538

FILED VS APR 26 1960

Registration District No. 314 Primary Registration District No. \_\_\_\_\_ Registrar's No. 151

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farmington-RURAL</u>		Length of stay in 1b <u>19 Days</u>		c. CITY OR TOWN <u>Wortham</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>M.A. Osteo Hosp.</u>			Inside Limits 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 checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle _____ Last <u>CAULEY</u>				4. DATE OF DEATH <u>April 17, 1960</u> Month _____ Day _____ Year _____			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>9/21/1869</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>26</u>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Cook County, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Mansfield Forster</u>			13b. MOTHER'S MAIDEN NAME <u>Luevina Hurst</u>		14. NAME OF HUSBAND OR WIFE <u>Henry W. Cauley</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>none</u>	17. INFORMANT Address <u>Mrs. Ethyl Henson Potosi, 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>HYPOSTATIC PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARDIAC FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>	
DUE TO (c) <u>FRAC. RT. FEMUR - SENILITY</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 _____ 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>3-30-60</u> to <u>4-17-60</u> and last saw her <sup>her</sup> alive on <u>4-17-60</u> . Death occurred at <u>7:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>C.E. Howell D.O.</u>				22b. ADDRESS <u>Flat River, Mo</u>		22c. DATE SIGNED <u>4/18/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/20/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Adams Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wortham, Mo.</u>		(State) _____	
24. FUNERAL DIRECTOR ADDRESS <u>Murphy L. Sparks Flat River, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Apr. 18, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</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. 589 working under my personal supervision.

Student

Richard A. Reeves

Signature of Student Embalmer

Signed

Murphy Sparks

Licensed Embalmer No. 4236

P. O. Address

St. Louis

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.