

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018759

FILED VS MAY 23 1960 75

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clinton</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Length of stay in 1b <b>3 mos.</b>		c. CITY OR TOWN <b>Cameron</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Comm. Hosp.</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R.R.#4</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>WAYNE</b> Last <b>UPCHURCH</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cauc.</b>	7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-27-1884</b>	9. AGE (last birthday) <b>75</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Wayne Co. Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>S.W. Upchurch</b>			13b. MOTHER'S MAIDEN NAME <b>Lucie Dishman</b>			14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Guy Upchurch, Cameron, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b>						<b>2 years</b>	
DUE TO (c) <b>arteriosclerotic Heart Disease</b>						<b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>2. obesity 3. arteriosclerotic (hypertrophic)</b>						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 _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>2-3-60</b> to <b>5-12-60</b> and last saw <sup>her</sup> him alive on <b>5-12-60</b> Death occurred at <b>7</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>St. Ketherton M.D.</b>				22b. ADDRESS <b>Cameron, Mo.</b>		22c. DATE SIGNED <b>5-14-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-16-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graceland</b>		23d. LOCATION (City, town, or county) (State) <b>Cameron, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Poland Funeral Home, Cameron, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>5-15-60</b>		26. REGISTRAR'S SIGNATURE <b>Francis Crawford</b>	

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert J. Polonsky

Licensed Embalmer No. 4777  
222 West  
P. O. Address Common

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.