

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018794

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Primary Registration District No. 3016 Registrar's No. 172

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>COLE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY, MO.</u> Length of stay in 1b _____ c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST MARYS HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>COLE</u> c. CITY OR TOWN <u>JEFFERSON CITY, MO.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>ALGOA RD. R. R. #</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CATHERINE</u> Last <u>RAITHEL</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/60</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>00</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (City and state or country) <u>Jefferson City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Cornelius henry raitchel</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Louise Scheuler</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>Cornelius Henry Raitchel J C 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><i>Cryptosporidiosis fetalis (fetal hydrops)</i></u> DUE TO (b) <u><i>Rh incompatibility</i></u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prematurity</u>				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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>May 7, 1960</u> to <u>May 8, 1960</u> and last saw her ^{her} <u>alive on May 8, 1960</u> . Death occurred at <u>11:30</u> <u>P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <u>John D. Dematt, M.D.</u>			22b. ADDRESS <u>Jefferson City, Mo.</u>		22c. DATE SIGNED <u>5-8-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/10/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION</u>	23d. LOCATION (City, town, or county) (State) <u>JEFFERSON CITY, MO.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Sylvester Galle</u>		25. DATE RECD. BY LOCAL REG. <u>J C MO. 13 May 1960</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Harris, M.D. - Richter, Dep.</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

James E. Gynard

Licensed Embalmer No. 4978

P. O. Address Jeff City

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.