

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS MAY 31 1960

=60-018799

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 194 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Osage</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		c. CITY OR TOWN <u>Chamois</u>	
Length of stay in 1b <u>1 day</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>St. Mary's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>None</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Dee</u> Last <u>Souder</u>			4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/02</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		11. BIRTHPLACE (City and state or country) <u>Denloe, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Dr. Lewis Souder</u>		13b. MOTHER'S MAIDEN NAME <u>Esther Workman</u>	
14. NAME OF HUSBAND OR WIFE <u>Alverta Souder</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.#2</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alverta Souder, Chamois, Mo.</u>		18. SOCIAL SECURITY NO.		17. INFORMANT Address	

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>Subarachnoid hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Arterio Sclerosis</u>		
DUE TO (c)		
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 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 checked="" type="checkbox"/> HOMICIDE <input checked="" 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>10:45</u> Month, Day, Year <u>5-25-60</u> 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 5-25-60 to 5-25-60 and last saw him alive on 5-25-60  
 Death occurred at 10:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. J. M. Fryly M.D.</u>	22b. ADDRESS <u>507 East High st.</u>	22c. DATE SIGNED <u>5-27-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/28/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>
23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo</u>	24. FUNERAL DIRECTOR <u>Thorpe J Gordon, Jefferson City, MO</u>	25. DATE RECD. BY LOCAL REG. <u>28 May 1960</u>
26. REGISTRAR'S SIGNATURE <u>R.P. Davis, MD - Richter, Dy</u>		

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

0961 2 - NDC SA

0961 9 - NDC SA

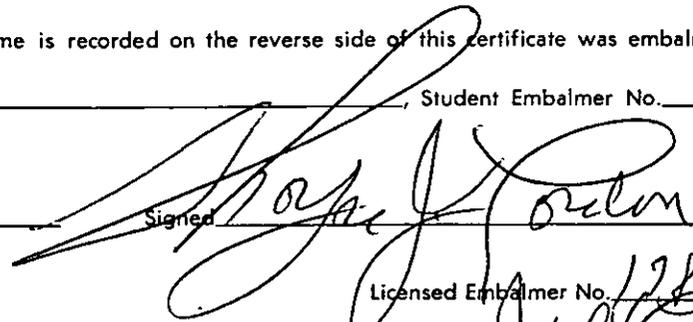
STATEMENT BY LICENSED EMBALMER

JUN 14 1960

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



Licensed Embalmer No. 1286

P. O. Address

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.