

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020575

FILED VS JUN 14 1960

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 227

DED

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</u>		Length of stay in 1b		c. CITY OR TOWN <u>FARMINGTON</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>219 E. LIBERTY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>219 E LIBERTY</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MALISSA</u> Middle <u>LOUISA</u> Last <u>THOMURE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-1869</u>	9. AGE (last birthday) <u>91</u>	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) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>STE. GENEVIEVE Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. A</u>
13a. FATHER'S NAME <u>JOHN F BEQUETTE</u>			13b. MOTHER'S MAIDEN NAME <u>NARCISSIS WOOLDRIDGE</u>			14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT <u>Joseph Thomure, Farmington, Mo.</u> 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>congestive failure - gas -</u> DUE TO (b) <u>senility -</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 _____ to _____ and last saw her <sup>her</sup> alive on <u>June 6 - 1960</u> <u>did not see</u> Death occurred at <u>8:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. Reynolds D.O.</u> (Degree or title)				22b. ADDRESS <u>Farmington Mo</u>		22c. DATE SIGNED <u>6-6-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>June 8, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT HILL</u>		23d. LOCATION (City, town, or county) (State) <u>NEAR FARMINGTON MO.</u>		
24. FUNERAL DIRECTOR <u>C.H. COZEAN FARMINGTON MO.</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>June 6, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Ether Redloff</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 *C. H. Cozart*

Licensed Embalmer No. 4084

P. O. Address Farmington

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