

BUREAU OF HEALTH - STANDARD CERTIFICATE OF DEATH

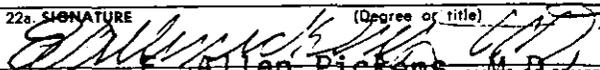
-60-025578

FILED VS JUL 6 1960

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 131

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp.</u> Length of stay in 1b <u>1yr. 2mo. 2days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. # 3</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Barry</u> c. CITY OR TOWN <u>Pierce City, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R. # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>O.</u> Last <u>Arfstrom</u>			4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>10-16-99</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR		
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 <u>Unknown</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jerry Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Geisler</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown - Deceased</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>Unknown</u>		17. INFORMANT <u>Records of Address</u> <u>State Hospital # 3, Nevada, 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>Coronary Vessel Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> DUE TO (b) <u>Atheromatous Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CBS Assoc. with Cir. Dist. with Cerebral Arteriosclerosis</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 type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>with Psychotic Reaction.</u>					
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>4-14-59</u> to <u>6-17-60</u> and last saw <u>him</u> alive on <u>6-17-60</u> Death occurred at <u>11:40 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) 			22b. ADDRESS <u>State Hosp. # 3, Nevada, Mo</u>		22c. DATE SIGNED <u>6-17-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>June 20, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pierce City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pierce City, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Ferry Funeral Home, Nevada, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>7-2-1960</u>		26. REGISTRAR'S SIGNATURE 			

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 L. Douglas Ferry

Licensed Embalmer No. 7960

P. O. Address Nevada

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.