

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025727

FILED VS AUG 8 1960 10

Registration District No. 4021 Primary Registration District No. 193

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Audrain</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Laddonia</b>		Length of stay in 1b <b>5 Month</b>		c. CITY OR TOWN <b>Laddonia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Britton Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Wilkins</b> Last <b>Torreyson</b>				4. DATE OF DEATH Month <b>7</b> Day <b>26</b> Year <b>1960</b>				
5. SEX <b>Fe Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6-15-1879</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Ralls County Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James W. Wilkins</b>			13b. MOTHER'S MAIDEN NAME <b>Robb</b>			14. NAME OF HUSBAND OR WIFE <b>Samuel T. Torreyson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Samuel T. Torreyson Laddonia Mo.</b> 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) <b>Congestive Circulatory Failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Prolonged Rumbling due to Gallop-Tachycardia</b>							<b>2 yrs</b>	
DUE TO (c) <b>Hypertension and Atherosclerosis</b>							<b>Unknown</b>	
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>April 1958</b> to <b>July 1960</b> and last saw her <b>him</b> alive on <b>7-26-60</b> Death occurred at <b>noon 7-26</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>William W Jones D.O.</b>				22b. ADDRESS <b>Laddonia Mo</b>			22c. DATE SIGNED <b>7-27-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-28-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laddonia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Laddonia, Mo.</b>				
24. FUNERAL DIRECTOR <b>Wilkey &amp; Bienhoff Laddonia, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>July 28 1960</b>		26. REGISTRAR'S SIGNATURE <b>Blanche Neely</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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *Alfred C. Kirk*

Licensed Embalmer No. 385

P. O. Address *Peru, Pa.*

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.