

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-026093
STATE FILE NUMBER

INDEXED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 199

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Callaway</u>	a. STATE <u>Mo</u>	b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Length of stay in lb <u>2 days</u>	c. CITY OR TOWN <u>Fulton</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>Callaway Memorial Hosp.</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>416 S.W. 9TH.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>Amanda</u>	Middle <u>Melvina</u>	Last <u>BROWN</u>	Month <u>July</u>	Day <u>20</u> Year <u>1960</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29-1892</u>	9. AGE (last birthday) <u>87</u>
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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Callaway Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>David Cove</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Hord</u>		14. NAME OF HUSBAND OR WIFE <u>John H. Brown</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 <u>Mrs Myra Clice</u> Address <u>416 S.W. 9th Fulton Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage, massive to hour</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma Gall bladder, postoperative</u>	
	DUE TO (c) <u>Chronic Cholelithiasis + cholelithiasis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Concurrent heart failure</u>		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 _____ a.m. _____ p.m.	Month, Day, Year _____

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 <u>2-17-60</u> to <u>7/20/60</u> and last saw her <u>7/19/60</u> and last saw him <u>7/19/60</u> alive on _____.				
Death occurred at <u>5:30</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>George W. Groce, MD.</u> (Degree or title)	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>7/21/60</u>
--	---------------------------------	---------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 22-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Mc Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>New Bloomfield Mo</u>
24. FUNERAL DIRECTOR <u>Claypool Service</u> ADDRESS <u>New Bloomfield Mo</u>	25. DATE RECD. BY LOCAL REG. <u>July 20-1960</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 9 1950

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 Le Roy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield

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.