

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026133

FILED VS AUG 9 1960

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Miss.					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		Length of stay in 1b 2 days		c. CITY OR TOWN Charleston		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cape Osteopathic Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Route 2, Box 356		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Sally Middle Ann Last Brown				4. DATE OF DEATH Month Aug. Day 2, Year 1960					
5. SEX Female	6. COLOR OR RACE Col.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1908	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months 51 Days	IF UNDER 24 HR Hours 51 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Brownsville, Tenn.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Unk.			13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE William Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Wm. Brown, R. 2, Box 356, Charleston, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post surgical shock & heart block							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) peritonitis & perforated gut									
DUE TO (c) Strangulated hernia & intest. stasis							48 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Nephritis, cardiac decompensation					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 5:50 Month, Day, Year July 31/60		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 WYATT, MO		20g. COUNTY WYATT STATE MO	
21. I attended the deceased from July 31/60 to Aug 2/60 and last saw her alive on Aug 2/60 Death occurred at 5:50 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE S. P. Fenton D.O. (Degree or title)				22b. ADDRESS WYATT, MO		22c. DATE SIGNED 8/4/60 (Sign)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 6, 1960	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) Charleston, Mo.				
24. FUNERAL DIRECTOR S. R. Sparks ADDRESS Charleston, Mo.			25. DATE RECD. BY LOCAL REG. 8-5-60		26. REGISTRAR'S SIGNATURE Jimm Kasten				

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oliver St. John

Licensed Embalmer No. 4190

P. O. Address Charles

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.