

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026611

STATE FILE NUMBER

FILED VS AUG 1 1960

133 Primary Registration District No. 3022 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Harrison</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Bethany</u>		Length of stay in 1b <u>53 Days</u>		c. CITY OR TOWN <u>Ridgeway Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) <u>Lucy Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1/2 m. S.W. Ridgeway</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Archer</u> Last <u>Curtis</u>				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>60</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-1424</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give nature of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Farming</u>		11. BIRTHPLACE (City and state or country) <u>Wagoning Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>Bradford Curtis</u>			13b. MOTHER'S MAIDEN NAME <u>Louise Van Buskirk</u>		14. NAME OF HUSBAND OR WIFE <u>Laura Grace Curtis</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>240</u>		17. INFORMANT <u>Laura Grace Curtis</u>			Address	
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>Congestive Heart Failure</u>							<u>0 mo</u>		
DUE TO (b) <u>Hypertensive Heart Disease</u>							<u>5 yrs.</u>		
DUE TO (c) <u></u>									
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 <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>									
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>8-4-59</u> , to <u>7-24-60</u> and last saw ^{her} him alive on <u>7-24-60</u> Death occurred at <u>4:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>G.H. Thwe</u> (Degree or title) <u>D.O.</u>				22b. ADDRESS <u>Bethany, Mo.</u>			22c. DATE SIGNED <u>7-25-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridgeway Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>1-m. W. Ridgeway Mo</u>				
24. FUNERAL DIRECTOR <u>Robert B Baggess</u> ADDRESS <u>Ridgeway Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-25-1960</u>		26. REGISTRAR'S SIGNATURE <u>Gella Mayes</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 Robert R. Boffner

Licensed Embalmer No. 95,76

P. O. Address Ridgeway

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.