

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-027543

FILED VS AUG 15 1960

184

Registration District No. Primary Registration District No. 3038 Registrar's No. 94

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Linn</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		Length of stay in 1b <b>15 yrs</b>		c. CITY OR TOWN <b>Brookfield</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>126 Grant Street</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>126 Grant Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Becca - Coram</b>				4. DATE OF DEATH Month Day Year <b>Aug. 5, 1960</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-5-1891</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and state or country) <b>Browning, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Chauncey Jerome</b>			13b. MOTHER'S MAIDEN NAME <b>Almeda Jane Baskett</b>			14. NAME OF HUSBAND OR WIFE <b>Arthur Coram</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Gilbert Coram, Brookfield, Mo.</b>			
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>Acute Coronary occlusion.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>D.O.P.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary insufficiency.</b>								
DUE TO (c) <b>Spurred Arteriosclerosis</b>							<b>2-4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>						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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>-</b>					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
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>8/3/60</b> to <b>8/5/60</b> and last saw her him alive on <b>D.O.P.</b> Death occurred at <b>11:30 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>D. W. Johnson M.D.</b>				22b. ADDRESS <b>Brookfield Mo.</b>			22c. DATE SIGNED <b>8/6/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-7-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Nester Chapel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>New Boston, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wright Funeral Home, Brookfield, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>8-6-60</b>		26. REGISTRAR'S SIGNATURE <b>Katharine Johnson Dep</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 16 1960

**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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo

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.