RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-027691

STATE FILE NUMBER

LED VS AUG 1 0 1960 Registration District No. 226 Primary Registration District No. 5802 Registrar's No. 33

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DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY MONROE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WOODLAWN TWP. Length of stay in 1b 1yr 8 MO.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8 MI. N.W. OF HOLLIDAY MO. Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY MONROE
c. CITY OR TOWN 8 MI. N. W. OF HOLLIDAY, MO. Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) WOODLAWN, TWP. R.F.D. HOLLIDAY, MO. Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle TEAGUE Last CRAIN

4. DATE OF DEATH Month JULY Day 29 Year 1960

5. SEX F

6. COLOR OR RACE W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4/18/1885

9. AGE (last birthday) 75 IF UNDER 1 YEAR Months 3 Days 11 IF UNDER 24 HR Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (City and state or country) SWEET SPRINGS, MO.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME UNKNOWN

13b. MOTHER'S MAIDEN NAME UNKNOWN

14. NAME OF HUSBAND OR WIFE RALPH G. CRAIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 509-36-8181

17. INFORMANT R. G. CRAIN Address R.F.D. HOLLIDAY, 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) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Instant
Conditions, If any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 7-29-60 to 7-29-60 and did not see her alive on 7-29-60
Death occurred at 9:05 A. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) F. A. Barnett MD. 22b. ADDRESS Paris, Mo. 22c. DATE SIGNED 7-29-60

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE AUGUST-1-1960 23c. NAME OF CEMETERY OR CREMATORY WALNUT GROVE CEM. 23d. LOCATION (City, town, or county) PARIS, MO. (State)

24. FUNERAL DIRECTOR E. H. AGNEW ADDRESS PARIS, MO

25. DATE RECD. BY LOCAL REG. Aug 1-1960

26. REGISTRAR'S SIGNATURE Edie Miller

(Licensed Embalmer's Statement on Reverse Side)

AUG 16 1960

AUG 18 1960

AUG 24 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_____ Signed E. H. Agnew

Signature of Student Embalmer

Licensed Embalmer No. 4000

P. O. Address Paris, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.