

21 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 14 1960

-60-029600
 STATE FILE NUMBER

Registration District No. 032 Primary Registration District No. 5114 Registrar's No. 622

1. PLACE OF DEATH a. COUNTY <u>BOLLINGER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>BOLLINGER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ARAB, Mo.</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>ARAB</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hy. 91 WAYNE Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Hy. 91. WAYNE Twp.</u>
3. NAME OF DECEASED (Type or print) First <u>ANGELIA</u> Middle <u>DONNETTE</u> Last <u>GAITHER</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) Months <u>9</u> Days <u>9</u> Hours <u></u> Min. <u></u>
13a. FATHER'S NAME <u>DONALD V. GAITHER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ALFARRETTA ROWE</u>	11. BIRTHPLACE (City and state or country) <u>Poplar Bluff, Mo.</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>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
17. INFORMANT <u>DONALD GAITHER - ARAB, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CIRCULATORY FAILURE</u>			<u>10 Min</u>
DUE TO (c) <u>PREMATURE LUNGS</u>			<u>BIRTH</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CONGENITAL DISEASE</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 <u></u> Month, Day, 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>SEPT 3-60</u> to <u>SEPT 3</u> and last saw <u>her</u> <u>him</u> alive on <u>SEPT 3-60</u> Death occurred at: <u>5:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R.G. Mastus J.O.</u>		22b. ADDRESS <u>Advance, Mo</u>	22c. DATE SIGNED <u>9-5-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-4-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SPEERS Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>BOLLINGER County, Mo.</u>
24. FUNERAL DIRECTOR <u>Wm H. Morgan, Advance, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-7-60</u>	26. REGISTRAR'S SIGNATURE <u>MW. Buford Crader</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 _____, Student Embalmer No. _____

or by _____, _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

W^m H. Meyer

Licensed Embalmer No. 464

P. O. Address Advance,

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