

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-030363

FILED VS AUG 29 1960

140

Primary Registration District No. 3024

Registrar's No. 83

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette</b>		Length of stay in 1b <b>10 days</b>		c. CITY OR TOWN <b>New Franklin</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>Lee Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>114 S. Missouri</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FANNIE OLIVIA VASPER</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>23,</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/3/1884</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days 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>Howard Co, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Ben Cropp</b>			13b. MOTHER'S MAIDEN NAME <b>Blanche Scripture</b>		14. NAME OF HUSBAND OR WIFE <b>Joe Vasper</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>Joe Vasper New Franklin, Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Chronic Hypertension</b> DUE TO (c) <b>Obesity</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs</b>	
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 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 Month, Day, Year s.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>8-15-60</b> to <b>8-23-60</b> and last saw her alive on <b>8-23-60</b> . Death occurred at <b>Fayette, Mo</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>W. A. Bloom, M.D.</b>				22b. ADDRESS <b>Fayette, Mo</b>		22c. DATE SIGNED <b>8-25-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/25/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fayette City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fayette, Missouri</b>			
24. FUNERAL DIRECTOR <b>Ralph A. Carr</b> ADDRESS <b>Fayette, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>8-25-60</b>		26. REGISTRAR'S SIGNATURE <b>Katherine Welch</b>		

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. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Fayette

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.