

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033602

FILED VS AUG 16 1960

360

6225

160

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Caldwell</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>		Length of stay in 1b <b>18 days</b>		c. CITY OR TOWN <b>Breckenridge</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital Number Three</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Arthur</b> Last <b>Moorshead</b>				4. DATE OF DEATH Month <b>8</b> Day <b>7</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-7-33</b>		9. AGE (last birthday) <b>27</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Breckenridge, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Vernon Moorshead</b>				13b. MOTHER'S MAIDEN NAME <b>Fern Gilliland</b>				14. NAME OF HUSBAND OR WIFE -----					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT Address <b>Records State Hospital #3, Nevada, 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>Broncho Pneumonia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>  <b>Yrs.</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary Tuberculosis (healed)</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) <b>Mental Deficiency, Severe.</b>													
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 _____ a.m. _____ p.m. Month, Day, Year _____		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>7-19-60</b> to <b>8-7-60</b> and last saw <sup>the</sup> him <sub>live</sub> on <b>8-7-60</b> Death occurred at <b>2:05 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>[Signature]</i> (Degree or title)						22b. ADDRESS <b>State Hospital #3, Nevada, Mo.</b>				22c. DATE SIGNED <b>8-7-60</b> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington University</b>				23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b> (State)					
24. FUNERAL DIRECTOR <b>Richard L. Shorten, Nevada, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>8-9-1960</b>				26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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 *Lloyd C McLeod*

Licensed Embalmer No. 4853

P. O. Address *Florida 77*

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.