

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034511

FILED VS SEP 19 1960

132

3021

155

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>GRUNDY</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo</u> b. COUNTY <u>GRUNDY</u></p>					
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRENTON</u></p>		<p>Length of stay in lb <u>2 years.</u></p>		<p>c. CITY OR TOWN <u>TRENTON</u></p>		<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>			
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wright Hosp. ANNEX</u></p>			<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>d. STREET ADDRESS (If outside, give location) <u>1012 Laclede</u></p>		<p>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine Boyd DANIEL</u></p>				<p>4. DATE OF DEATH Month Day Year <u>Sept. 9 1960</u></p>					
<p>5. SEX <u>female</u></p>		<p>6. COLOR OR RACE <u>white</u></p>		<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>2/18/1881</u></p>		<p>9. AGE (last birthday) <u>79</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>—</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Breckenridge, Mo</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>			
<p>13a. FATHER'S NAME <u>Henry Boyd</u></p>			<p>13b. MOTHER'S MAIDEN NAME <u>MARY Stagner</u></p>			<p>14. NAME OF HUSBAND OR WIFE <u>W.S. DANIEL (dec)</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p>			<p>16. SOCIAL SECURITY NO. <u>—</u></p>		<p>17. INFORMANT Address <u>John DANIEL Trenton, Mo</u></p>				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>							<p>INTERVAL BETWEEN ONSET AND DEATH</p>		
<p>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u></p>							<p><u>2 days</u></p>		
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>DUE TO (b) <u>diabetes &amp; arteriosclerosis</u></p>							<p><u>2 days</u></p>		
<p>DUE TO (c) <u>—</u></p>							<p><u>—</u></p>		
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>						<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown</p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>					
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>			
<p>21. I attended the deceased from <u>1957</u> to <u>Sept 9, 1960</u> and last saw her <u>Sept 9 1960</u> alive on <u>Sept 9 1960</u></p> <p>Death occurred at <u>10:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>									
<p>22a. SIGNATURE <u>[Signature]</u> (Degree or title)</p>				<p>22b. ADDRESS <u>Trenton Mo</u></p>		<p>22c. DATE SIGNED <u>9/10/60</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>9/11/1960</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORIUM <u>5007 Edinburg</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>Edinburg Mo</u></p>			
<p>24. FUNERAL DIRECTOR <u>Gordon Blackman</u> ADDRESS <u>Trenton, Mo.</u></p>				<p>25. DATE RECD. BY LOCAL REG. <u>9-15-60</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 23 1960

OCT 13 1980

**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 *Gordon Blackmer*

Licensed Embalmer No. 4602

P. O. Address Trenton, NJ

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.