

# FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035454

FILED VS OCT 11 1960

Registration District No. 195 Primary Registration District No. \_\_\_\_\_ Registrar's No. 83-60

STATE FILE NUMBER

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |  |  |  |
| a. COUNTY<br><b>McDonald</b>   |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><b>Anderson</b>   |   | Length of stay in 1b<br><b>All Life</b>  |  | c. CITY OR TOWN<br><b>Anderson</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>Home</b>   |  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         |  | d. STREET ADDRESS (If outside, give location)  |  |
| 3. NAME OF DECEASED (Type or print)  |  | First<br><b>Dianna</b>  |   | Middle<br><b>Lynn</b>  |  | Last<br><b>Mitchell</b>  |  |
| 4. DATE OF DEATH   |  | Month<br><b>Oct</b>   |   | Day<br><b>5</b>  |  | Year<br><b>1960</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-1-1960</b>         | 9. AGE (last birthday)   | IF UNDER 1 YEAR<br>Months <b>9</b> Days _____ Hours _____ Min. _____ | IF UNDER 24 HR<br>Hours _____ Min. _____   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Child</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>Neosho, Mo</b>                              |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>Ray Mitchell</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Jeffers</b> |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Child</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br>Address<br><b>Mr Mrs Ray Mitchell Anderson</b>                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b>   |  |   |   |  |  |  | <b>Subacute</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral palsy</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.  | Month, Day, Year   |   |   |  |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>Jan 1 1960</b> to <b>Oct 5 1960</b> and last saw her alive on <b>Sept 21 1960</b><br>Death occurred at <b>2:15 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>M. L. Carter M.D.</b>   |  |   |   | 22b. ADDRESS<br><b>Neosho Mo</b>   |  | 22c. DATE SIGNED<br><b>10-7-60</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>10-7-1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anderson Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Anderson, Missouri</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Clark Funeral Home</b>  |  |   | ADDRESS<br><b>Neosho, Mo</b>                |  | 25. DATE RECD. BY LOCAL REG.<br><b>Oct 7, 1960</b>                   |  | 26. REGISTRAR'S SIGNATURE<br><b>Mary P. Brasley</b><br><b>J. R. CARTER, M.D.</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Fred L. Clark

Licensed Embalmer No. 5054

P. O. Address 312 So. W.  
Neosho Mo

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.