

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS SEP 26 1960

-60-035773

UNDED

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 287

STATE FILE NUMBER

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Randolph | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly | | Length of stay in 1b 51 Yrs. | | c. CITY OR TOWN Moberly | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 617 Promenade | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 617 Promenade | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ADA Middle CODNER Last CODNER | | | | 4. DATE OF DEATH Month SEPT. Day 13 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 1-28-1875 | 9. AGE (last birthday) 85 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Grundy County, Illinois | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME Charles Reed | | | 13b. MOTHER'S MAIDEN NAME Elizabeth Hook | | | 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) No | | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Mrs. Zula Criss | | Address Moberly | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, UNSPECIFIED VESSEL | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIO SCLEROSIS | | | | | | | UNKNOWN |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PSYCHOSIS WITH CEREBRAL ARTERIO SCLEROSIS | | | | | 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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 about Sept 7 1958 to Sept 15 1960 and last saw her alive on Sept 4, 1960 Death occurred at 1:30 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Clarence Clodes M.D. | | | | 22b. ADDRESS 317 Virginia, Moberly | | 22c. DATE SIGNED Sept 15, 1960 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Sept. 15, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens | | 23d. LOCATION (City, town, or county) Moberly | | 23e. (State) Mo. | |
| 24. FUNERAL DIRECTOR Mahan Funeral Service ADDRESS Moberly | | | | 25. DATE RECD. BY LOCAL REG. 9-15-60 | | 26. REGISTRAR'S SIGNATURE Leah Blaine | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 8 1960

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

John A. Green

Licensed Embalmer No. 3815

P. O. Address Moberly, 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.