

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-037215

FILED VS SEP 20 1960

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 177 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		c. CITY OR TOWN <u>El Dorado Springs</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>#812 N. Washington</u> <u>Tates Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>Hickory St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Lee</u> Last <u>Deering</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Henry Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Thomas Gilbert</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Bryan</u>		14. NAME OF HUSBAND OR WIFE <u>Sanford Deering</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Grace Marshall, El Dorado Spgs. Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>		DUE TO (b) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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. <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 checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		STATE

21. I attended the deceased from June 16 60 to _____ and last saw her/him alive on _____
Death occurred at 3:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>L.P. McCann</u> <u>L.P. McCann, M. D.</u>	22b. ADDRESS <u>Moore Bldg., Nevada, Mo.</u>	22c. DATE SIGNED <u>9/13/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-15-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harwood, Missouri</u>
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24. FUNERAL DIRECTOR <u>Guinn-Carother's, El Dorado Spgs. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-17-1960</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Jerry</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 May W. Dickerson

Licensed Embalmer No. 467

P. O. Address Ed Para

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.