

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037749

FILED VS NOV 9 1961

Registration District No. 61

Primary Registration District No. ~~15~~

Registrar's No. 33

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cedar</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>El Dorado Springs</u>		Length of stay in 1b		c. CITY OR TOWN <u>El Dorado Springs</u>		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>314 Ohio</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>314 Ohio</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Tilman</u> Middle <u>G.</u> Last <u>Renfro</u>				4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>60</u>				
5. SEX <u>male</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>5-5-1877</u>	9. AGE (last birthday) <u>83</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>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Fairfield Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William Renfro</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Spanish-Am.</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joe Renfro--El Dorado Springs, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>							<u>1 day</u>	
DUE TO (b) <u>Arteriosclerosis</u>							<u>Years</u>	
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20a. 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 <u>11/2/60</u> to <u>11/5/60</u> and last saw <input checked="" type="checkbox"/> him <input type="checkbox"/> her alive on <u>11/5/60</u> Death occurred at <u>3:00</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Wm. C. Sundermuth, D.O.</u>				22b. ADDRESS <u>El Dorado Springs, Missouri</u>		22c. DATE SIGNED <u>11/5/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-6-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Viroll City Cemetery</u>		23d. LOCATION (City, town, or county) <u>Vernon Co., Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Guinn-Carothers--El Dorado Spgs., Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-5-60</u>		26. REGISTRAR'S SIGNATURE <u>Hugh S. Allen</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

certify

NOV 15 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 Max W. Suckers

Licensed Embalmer No. 469

P. O. Address El Dorado

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.