

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 18 1960 77

-60-022845  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 5302 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clark Township</u>		Length of stay in 1b		c. CITY OR TOWN <u>Marshall</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Highway # 17, Eugene</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route # 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MISS KAREN KAY ANGLEN</u>				4. DATE OF DEATH Month Day Year <u>October 10, 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-1943</u>	9. AGE (last birthday) <u>16</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Saline County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Francis William Anglen</u>			13b. MOTHER'S MAIDEN NAME <u>Flora May Phillips</u>			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) <u>No</u>			16. SOCIAL SECURITY NO. <u>497-42-9960</u>		17. INFORMANT Address <u>Mr. Francis Anglen Route #3, Marshall, 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>Crushing head &amp; chest injuries instant</u>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Was thrown from car as brakes lost control</u>					
20c. TIME OF INJURY Hour _____ a.m. _____ <u>approx 12:00pm</u>		Month, Day, Year <u>10/10/60</u>		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.) <u>Highway</u>			20f. CITY, TOWN, OR LOCATION <u>Eugene (Clark Township) Cole, Mo</u>		20g. COUNTY STATE		
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Clarence K. Corcoran, Coronet Cole County</u>				22b. ADDRESS <u>1436 Green Berry Pl. City, Mo.</u>		22c. DATE SIGNED <u>10/10/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem &amp; Bur</u>		23b. DATE <u>Oct. 12, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rich Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Marshall, Mo.</u>		
24. FUNERAL DIRECTOR <u>Victor Bressler</u>				25. DATE RECD. BY LOCAL REG. <u>11 October 1960</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Davis, M.D. - Richter Dep</u>	

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

for by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Vernon Moxton*

Licensed Embalmer No. 4125

P. O. Address Levin W

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.