

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038950
STATE FILE NUMBER

FILED VS NOV 9 1960

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 203

| | | | | | | | | |
|--|---|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Livingston | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Caldwell | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe | | Length of stay in lb 11 days | | c. CITY OR TOWN Cowgill | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chillicothe Hosp | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARTHA Middle BELLE Last CLEVENGER | | | | 4. DATE OF DEATH Month Oct. Day 14 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 Feb, 9, 1883 | 9. AGE (last birthday) 77yrs | 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) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Hughson Allen | | | 13b. MOTHER'S MAIDEN NAME Mary ----- | | | 14. NAME OF HUSBAND OR WIFE deceased | | |
| 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 Address Helen Pitts, Braymer, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Terminal Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral embolus DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 11 days | |
| 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 | | COUNTY | | STATE | | |
| 21. I attended the deceased from Aug 1-60 to Oct. 14-60 and last saw her ^{her} _{him} alive on Oct. 13-60 Death occurred at 8:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Joseph A. Conrad MD | | | | 22b. ADDRESS Chillicothe, Mo | | | 22c. DATE SIGNED 10/15/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE Oct. 16, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Cowgill E. Vaughan Cem. | | 23d. LOCATION (City, town, or county) (State) Cowgill, Mo | | | |
| 24. FUNERAL DIRECTOR ADDRESS Mead-Pitts Funeral Service, Braymer, Mo | | | | 25. DATE RECD. BY LOCAL REG. Oct 15, 1960 | | 26. REGISTRAR'S SIGNATURE Annaliese Taylor | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

13577

(Licensed Embalmer's Statement on Reverse Side)

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 *Dernard J. Mead*

Licensed Embalmer No. 2801

P. O. Address Braymer, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.