

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039422

LED VS OCT 31 1960

Registration District No. 314 Primary Registration District No. 6064 Registrar's No. 5961 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola - rural</u>		Length of stay in lb <u>2 yrs</u>		c. CITY OR TOWN <u>Osceola</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Waitas Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>T.</u> Last <u>Parsons</u>				4. DATE OF DEATH Month <u>Oct</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>1/23/68</u>		9. AGE (last birthday) <u>92</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>Housekeeping</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Chenango Forks New York N.YJ</u>		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME <u>William Terwilliger</u>				13b. MOTHER'S MAIDEN NAME <u>Rebecca Worrick</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>None</u>		17. INFORMANT <u>Family Record, Osceola</u> Address							
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 hemorrhage</u> DUE TO (b) <u>Cerebral hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>Monday</u>			
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 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 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 <u>1-23-68</u> to <u>10-13-60</u> and last saw her alive on <u>9-30-60</u> Death occurred at <u>3:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Muth Seewers MD</u> (Degree or title)						22b. ADDRESS <u>Osceola Mo</u>			22c. DATE SIGNED <u>10-14-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Whitney Point</u>		23d. LOCATION (City, town, or county) <u>Whitney Point, -</u>		23e. (State) <u>Mo</u>					
24. FUNERAL DIRECTOR <u>Goodrich FUNeral Home, Osceola Mo;</u> ADDRESS						25. DATE RECD. BY LOCAL REG. <u>10/15-60</u>		26. REGISTRAR'S SIGNATURE <u>Muth Seewers</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Paul J. [unclear]

Licensed Embalmer No. 3990

P. O. Address Oscoda

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.