

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039447

FILED VS OCT 18 1960

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 397 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farmington</u>		c. CITY OR TOWN <u>FARMINGTON</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>407 E. Columbia St.</u>		d. STREET ADDRESS (If outside, give location) <u>407 E Columbia</u>	

3. NAME OF DECEASED (Type or print) First <u>SALLY</u> Middle _____ Last <u>CALER</u>	4. DATE OF DEATH Month <u>OCT.</u> Day <u>11</u> Year <u>1960</u>
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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>7/8/89</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>UNION CITY TENN.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>SAMUEL NEAL</u>	13b. MOTHER'S MAIDEN NAME <u>HENRIETTA STANLEY</u>	14. NAME OF HUSBAND OR WIFE _____
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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 Address <u>MRS. BILL HUNT FARMINGTON MO.</u>
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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>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial Infarction</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) <u>Probable Pulmonary Embolism</u>	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
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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.) _____
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from Nov. 1959 to Oct. 11, '60 and last saw her alive on Oct. 11, 60
Death occurred at 5 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Alan Karaku M.D.</u> (Deedee or title)	22b. ADDRESS <u>Farmington, Mo</u>	22c. DATE SIGNED <u>10/13/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/14/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK VIEW</u>	23d. LOCATION (City, town, or county) (state) <u>NEAR FARMINGTON MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>C.H. COZEAN FARMINGTON MO</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 14, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>
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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 _____

Licensed Embalmer No. 40

P. O. Address Farmington

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.