

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040793

STATE FILE NUMBER

FILED VS NOV 14 1960

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>Taney</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Taney</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Forsyth</u>		Length of stay in 1b		c. CITY OR TOWN <u>Forsyth</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeview Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Lakeview Rest Home</u>			Reside on Farm. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL MAUDE MARY SMITH</u>				4. DATE OF DEATH Month Day Year <u>Nov. 6, 1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/6/87</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (City and state or country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Ross Hawkins</u>			13b. MOTHER'S MAIDEN NAME <u>Ada Hawkins</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Phillip Brinkman, Branson, 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>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arterial Hypertension</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 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>9-9-60</u> to <u>11-6-60</u> and last saw her/him alive on <u>11-5-60</u> Death occurred at <u>11-6-60</u> <u>7:00 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Mary King, D.O.</u>				22b. ADDRESS <u>Forsyth, Mo.</u>		22c. DATE SIGNED <u>11-7-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>11/9/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Washington</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Whelchel Chapel, Branson, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>11-10-60</u>		26. REGISTRAR'S SIGNATURE <u>DeWitt Campbell</u>	

(Licensed Embalmer's Statement on Reverse Side)

DED

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 Walter Cook

Licensed Embalmer No. 473

P. O. Address Branson

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.

Walter Cook *CSA*