

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040809

LED VS NOV 3 1960

Registration District No. 356 Primary Registration District No. 6209 Registrar's No. 90

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Texas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Texas</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bucyrus</u>		Length of stay in 1b		c. CITY OR TOWN <u>Bucyrus</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			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Debra</u> Middle <u>Irene</u> Last <u>Pearcy</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/59</u>	9. AGE (last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u>	IF UNDER 24 HR Hours <u>25</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Houston, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ray Percy</u>			13b. MOTHER'S MAIDEN NAME <u>Norma Campbell</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>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Ray Percy, Bucyrus, Missouri</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>Congestive Heart Failure</u> DUE TO (b) <u>Bronchopneumonia</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>24 hr.</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"/> N. <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 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>Pronounced patient dead</u> and last saw her <u>5:45 A</u> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Joe A. Wall MD</u> (Degree or title)				22b. ADDRESS <u>Houston, Missouri</u>			22c. DATE SIGNED <u>10-22-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/23/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hickory Elm Cel</u>		23d. LOCATION (City, town, or county) <u>Texas County, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Isabella T. Dunn, Houston, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Oct. 27 - 60</u>		26. REGISTRAR'S SIGNATURE <u>M. J. Craig</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 Frank E. Howard

Licensed Embalmer No. 4076

P. O. Address Howerton,

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.