

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041787

FILED VS DEC 5 1960

140

3024

106

STATE FILE NUMBER

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Howard | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette | | Length of stay in 1b 9 days | | c. CITY OR TOWN Franklin | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) R. R. 1 | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Linwood Middle Brown Last AMICK | | | | 4. DATE OF DEATH Month Nov. Day 29 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 8, 1879 | 9. AGE (last birthday) 80 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR. Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | | 10b. KIND OF BUSINESS OR INDUSTRY Self | | 11. BIRTHPLACE (City and state or country) Howard County, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME William Preston Amick | | | 13b. MOTHER'S MAIDEN NAME Alice Chancellor | | 14. NAME OF HUSBAND OR WIFE Maud Short Amick | | |
| 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 Mrs. Maud Amick Rt 1 Franklin, Mo. 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) Cerebral thromboses | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - fracture of rt. hip - 11 days. | | | | | 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 checked="" 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.) Fall in home | | | | |
| 20c. TIME OF INJURY 7 Hour Nov. 18-60 a.m. p.m. | | | | | | | |
| 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.) Home | | 20f. CITY, TOWN, OR LOCATION Franklin, Howard, Mo. | | STATE | |
| 21. I attended the deceased from Nov. 20-60 to Nov. 29-60 and last saw him alive on 11-27-60 Death occurred 9:35 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Wm G. Shaw, M.D. (Degree or title) | | | | 22b. ADDRESS Fayette Mo | | 22c. DATE SIGNED 12-2-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Dec. 2, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Clark's Chapel Cem. | | 23d. LOCATION (City, town, or county) (State) Howard County, Missouri | | | |
| 24. FUNERAL DIRECTOR Markland - Hall New Franklin, Mo. ADDRESS | | | 25. DATE RECD. BY LOCAL REG. 12-2-60 | 26. REGISTRAR'S SIGNATURE Katherine Welch | | | |

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 Tom D. Markland

Licensed Embalmer No. 4592

P. O. Address New Franklin

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.