

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-042716

ED VS DEC 12 1960

STATE FILE NUMBER

Registration District No. 386 Primary Registration District No. 3039 Registrar's No. 162

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Linn</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>		Length of stay in 1b <u>3da</u>		c. CITY OR TOWN <u>Marceline</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>230 E. Howell</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Staples</u> Last <u>Staples</u>				4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>60</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-30-1889</u>		9. AGE (last birthday) <u>80</u>	
						IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Chariton Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>James</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Crawley</u>			14. NAME OF HUSBAND OR WIFE <u>Lou</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>30246524</u>		17. INFORMANT <u>Mitchell Staples Marceline Mo</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>No Primary Thrombotic Stroke</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ 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) <u>Severe Sarcoidosis + Dermatitis Senevolis</u>								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 _____ a.m. _____ p.m. Month, Day, Year _____		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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>1953</u> to <u>1960</u> and last saw ^{her} him alive on <u>12-3-60</u> Death occurred at <u>12-3-60 5:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>121 N KANSAS AVE MARCELINE, Missouri</u>				22c. DATE SIGNED <u>12-5-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12-5-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Marinet</u>		23d. LOCATION (City, town, or county) (State) <u>Marceline Mo.</u>			
24. FUNERAL DIRECTOR <u>James McLaughlin</u> ADDRESS <u>Marceline Mo</u>				25. DATE RECD. BY LOCAL REG. <u>12-5-60</u>		26. REGISTRAR'S SIGNATURE <u>Bronnie Owens</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ROBERT W. SMITH 1910.

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 Gerald F. Wa

Licensed Embalmer No. 4172

P. O. Address Brown

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.