

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044874

FILED VS NOV 21 1960

STATE FILE NUMBER

Registration District No. 261 Primary Registration District No. 4515 Registrar's No. 9F

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Sullivan</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Length of stay in 1b <u>1 1/2</u>		c. CITY OR TOWN <u>Osgood</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>S.C.M. Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Bauman Sup.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE ORAB PRIVITT</u>				4. DATE OF DEATH Month Day Year <u>11-16-1960</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>1-25-1888</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Sullivan Co MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Jasper Privitt</u>				13b. MOTHER'S MAIDEN NAME <u>Ludie J West</u>				14. NAME OF HUSBAND OR WIFE <u>Oma Stokely Privitt</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mrs Oma Privitt Osgood 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>C.A. Liver</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>C.A. sigmoid</u> DUE TO (c) <u>C.A. Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Surgery 1959 Duodenal &amp; sigmoid</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>1959</u> <u>1958</u>					
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>11-14-60</u> to <u>11-16-60</u> and last saw him alive on <u>11-16-60</u> Death occurred at <u>6:55 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>E. Simpson D.O.</u>						22b. ADDRESS <u>Milan</u>				22c. DATE SIGNED <u>11-16-60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)							
<u>Burial</u>		<u>11-18-1960</u>		<u>Camp Ground Cem.</u>				<u>Osgood MO</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Payne Funeral Home Salt MO</u>				25. DATE RECD. BY LOCAL REG. <u>11-16-60</u>				26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beckett</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 *P. K. Payne Jr*

Licensed Embalmer No. 340

P. O. Address Galt

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.