

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045786

FILED VS JAN 9 1961  
ENDED

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. \_\_\_\_\_ Registrar's No. 12718

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Greene</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Republic</u>		a. STATE <u>Missouri</u> COUNTY <u>Greene</u>		c. CITY OR TOWN <u>Republic</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Republic</u>		Length of stay in 1b		c. CITY OR TOWN <u>Republic</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>Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 mi. west</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Jess</u>		Middle <u>Walter</u>		Last <u>Blades</u>		Month <u>Dec.</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-20-1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Republic, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Gedion Blades</u>			13b. MOTHER'S MAIDEN NAME <u>Rachel Ray</u>		14. NAME OF HUSBAND OR WIFE <u>Nora Hayes</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.		17. INFORMANT <u>Wayne Blades</u>		Address <u>Republic, 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-THROMBOSIS</u>							INTERVAL BETWEEN ONSET AND DEATH
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)					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 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>12-20-60</u> to <u>12-20-60</u> and last saw her/him alive on <u>12-20-60</u> Death occurred at <u>unknown</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. Mitchell Wo.</u> (Degree or title)				22b. ADDRESS <u>Republic, Mo</u>		22c. DATE SIGNED <u>12-23-1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-24-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wade Cemetery</u>		23d. LOCATION (City, town, or county) <u>Republic, Mo</u> (State)		
24. FUNERAL DIRECTOR <u>H.B. Cantrell</u>		ADDRESS <u>Republic, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-5-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Nelson</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 William D. Conley

Licensed Embalmer No. 4820

P. O. Address Republic

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.