

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-046668

FILED VS DEC 28 1960

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 190

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in 1b <u>15 hrs.</u>		c. CITY OR TOWN <u>Lebanon Rural</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>Wallace Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Oakland Star Rte.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Florence</u> Last <u>Chastain</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</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>11/2/1906</u>		9. AGE (last birthday) <u>54</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Laclede Co. Mo U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Henry Wilson</u>				13b. MOTHER'S MAIDEN NAME <u>Mary Adams</u>				14. NAME OF HUSBAND OR WIFE <u>Alfred</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>497-03-6120</u>		17. INFORMANT <u>Alfred Chastain Lebanon 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>Cerebral vascular accident - hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>malignant hypertension</u>										<u>8 yrs.</u>			
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 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>7-17-60</u> to <u>12-17-60</u> and last saw her <u>live</u> on <u>12-17-60</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 <u>B B Hurst, M.D.</u>				22b. ADDRESS <u>Lebanon, Mo.</u>				22c. DATE SIGNED <u>12-19-60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/19/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>		23d. LOCATION (City, town, or county) <u>Laclede Co. Mo.</u>		(State)					
24. FUNERAL DIRECTOR <u>Dorsey M. Howe</u>				ADDRESS <u>Lebanon Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-19-1960</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. Day</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 Dorsey M. Howe

Licensed Embalmer No. 422

P. O. Address Lebanon

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.