

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-047000**

FILED VS JAN 4 1961

STATE FILE NUMBER

Registration District No. 272 Primary Registration District No. 4 Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Pennselt</u>	a. STATE <u>7110</u>	b. COUNTY <u>Pennselt</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Steck</u>	Length of stay in 1b	c. CITY OR TOWN <u>Steck</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	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>502 Railroad St</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>			
First <u>May</u>	Middle <u>Williams</u>	Last	Month <u>12</u>	Day <u>22</u>	Year <u>60</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>Col</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1890</u>	<b>9. AGE (last birthday)</b> <u>70</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Lenk</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>			

<b>13a. FATHER'S NAME</b> <u>Lenk</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Lenk</u>	<b>14. NAME OF HUSBAND OR WIFE</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <u>Ora Ballard</u> Address <u>Steck 330</u>

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <u> Died without medical aid no foul play</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)		<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>[Signature]</u> (Degree or title) <u>Local Registrar</u>	<b>22b. ADDRESS</b> <u>Steck 330</u>	<b>22c. DATE SIGNED</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u>	<b>23b. DATE</b> <u>12-23-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holly Grove</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Steck, Mo</u>
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<b>24. FUNERAL DIRECTOR</b> <u>German Funeral Home</u> ADDRESS <u>Steck, Mo</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-26-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>
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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 Jim F. McClure

Licensed Embalmer No. 5104

P. O. Address Steele, Mo

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.