

# JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047165

OFFICE OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 296 Primary Registration District No. 4444 Registrar's No. 15

FILED VS DEC 19 1960

|  |  |   |  |   |   |  |  |
|--|--|---|--|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Ray</u><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Camden Township</u> Length of stay in 1b OR TOWN <u>4 Yrs.</u><br>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At brothers home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u><br>c. CITY OR TOWN _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Josie</u> Middle <u>Georgene</u> Last <u>Jellum</u>   |  |   | <b>4. DATE OF DEATH</b><br>Month <u>Dec.</u> Day <u>11</u> Year <u>1960</u>  |   |   |  |  |
| <b>5. SEX</b><br><u>Female</u>   | <b>6. COLOR OR RACE</b><br><u>White</u>  | <b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/><br><b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>2-5-1876</u>   | <b>9. AGE</b> (last birthday) <u>84</u><br>IF UNDER 1 YEAR Months _____ Days _____<br>IF UNDER 24 HR Hours _____ Min. _____   |   |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (City and state or country) <u>Clay Center, Kansas, U.S.A.</u>  |   |  |  |
| <b>13a. FATHER'S NAME</b><br><u>Andrew Jellum</u>  |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><u>Karen Stixrod</u>  |  | <b>14. NAME OF HUSBAND OR WIFE</b><br><u>None</u>   |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>   |  | <b>17. INFORMANT</b> Address<br><u>Martin Don Jellum Orrick, Missouri</u>   |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u><br>DUE TO (c) _____   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>_____   |   |  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____   |  |   |  |   |   |  |  |
| <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input 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  |   |  |  |
| <b>21. I attended the deceased from</b> <u>1-1-60</u> to <u>12-11-60</u> and last saw her alive on <u>12-11-60</u><br>Death occurred at <u>9:25 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |   |   |  |  |
| <b>22a. SIGNATURE</b> (Degree or title)<br><u>Jeffrey F. Summers M.D.</u>  |  |   | <b>22b. ADDRESS</b><br><u>Orick, Mo</u>  |   | <b>22c. DATE SIGNED</b><br><u>12-12-60</u>                                      |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL, (Specify)</b><br><u>Burial</u>   |  | <b>23b. DATE</b><br><u>12-14-1960</u>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>South Point Cemetery</u>   |   | <b>23d. LOCATION</b> (City, town, or county) (State)<br><u>Orrick, Missouri</u> |  |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><u>Wilbur M. Ayle Orrick, Missouri</u>  |  |   | <b>25. DATE RECD. BY LOCAL REG.</b><br><u>12-15-60</u>   |   | <b>26. REGISTRAR'S SIGNATURE</b><br><u>Helen J. Larkin</u>                      |  |  |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 31 1961

### 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 \_\_\_\_\_  
Licensed Embalmer No. 458

P. O. Address \_\_\_\_\_

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.