

II DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047225

STATE FILE NUMBER

LED VS DEC 2 0 1960

316

Primary Registration District No. 3060

Registrar's No. 491

ED

1. PLACE OF DEATH a. COUNTY ST FRANCOIS			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST FRANCOIS		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FARMINGTON MO.		Length of stay in 1b	c. CITY OR TOWN FARMINGTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1301 N. Washington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1301 N wash.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last LEAH B RARIDEN			4. DATE OF DEATH Month Day Year DEC. 15 1960		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/29/96	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (City and state or country) BONNE TERRE MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME J. W. BOWMAN		13b. MOTHER'S MAIDEN NAME ADALINE WILKSON		14. NAME OF HUSBAND OR WIFE LYNN RARIDEN	
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 LYNN RARIDEN FARMINGTON MO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)	ACUTE CIRCULATORY FAILURE			10mi
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	CORONARY THROMBOSIS - OLD + NEW		10mi
	DUE TO (c)	CHRONIC MYOCARDIAL INSUFFICIENCY -		10da
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) VIRUS PNEUMONITIS			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 s.m. p.m.	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 1954 to 1960 and last saw her/him alive on 12-14-60
Death occurred at 12:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>M. C. ...</i>	22b. ADDRESS <i>Farmington Mo</i>	22c. DATE SIGNED <i>12-16-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/18/60	23c. NAME OF CEMETERY OR CREMATORY HILL VIEW MEMORIAL
23d. LOCATION (City, town, or county) FARMINGTON MISSOURI		

24. FUNERAL DIRECTOR C.H. COZEAN FARMINGTON MO.	ADDRESS <i>marcus</i>	25. DATE RECD. BY LOCAL REG. Dec. 16, 1960	26. REGISTRAR'S SIGNATURE <i>Catherine Reddick</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 28 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 _____
C. H. Coyle

Licensed Embalmer No. 40

P. O. Address Tampa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.