

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS DEC 19 1960

-60-048490

STATE FILE NUMBER

Registration District No. 361 Primary Registration District No. 4515 Registrar's No. 106

DED

1. PLACE OF DEATH a. COUNTY Sullivan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Sullivan					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan		Length of stay in 1b 13 yrs		c. CITY OR TOWN Milan		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sul. Co Mem'l Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Elmer Middle Winiford Last Sevier				4. DATE OF DEATH Month Dec. Day 12, Year 1960					
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-30-86	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming-Stock Raising			10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming		11. BIRTHPLACE (City and state or country) Sullivan County U. S. A		12. CITIZEN OF WHAT COUNTRY U. S. A		
13a. FATHER'S NAME James Washington Sevier			13b. MOTHER'S MAIDEN NAME Lena Troyer			14. NAME OF HUSBAND OR WIFE Pearl Sevier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 497-40-6707		17. INFORMANT J. W. Sevier Milan, Mo				
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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"/> N- <input type="checkbox"/> Unknown							INTERVAL BETWEEN ONSET AND DEATH 12 hours		
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 checked="" 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 12-11-60 to 12-12-60 and last saw him alive on 12-12-60 Death occurred at 5:55 A on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE V. Robinson DO (Degree or title)				22b. ADDRESS Milan Mo				22c. DATE SIGNED 12-14-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 13, 60	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town, or county) Milan		STATE Mo		
24. FUNERAL DIRECTOR Legg Funeral Home ADDRESS Milan			25. DATE RECD. BY LOCAL REG. 12-15-60		26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 20 1960

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. 3792

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.