

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001817

FILED VS JAN 24 1961

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 13

STATE FILE NUMBER

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jasper			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jasper		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 1 week	c. CITY OR TOWN Carthage		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune Brooks Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Fair Acres	
3. NAME OF DECEASED (Type or print) First Rachel Middle B. Last Daniel			4. DATE OF DEATH Month Jan. Day 15 Year 1961		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Apr. 30, 1884	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (City and state or country) Sarcoxie, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME W. F. Burkholder		13b. MOTHER'S MAIDEN NAME Nancy M. Denny	
14. NAME OF HUSBAND OR WIFE James Daniel		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. no	
17. INFORMANT Cloyd Burkholder, Rte. 1, Granby, 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) Arteriosclerosis, general		DUE TO (b) Cerebral Arteriosclerosis		Sev. mos.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (c) Arteriosclerotic heart disease		Sev. mos.	
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 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 Month, Day, Year a.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 <u>10/28/60</u> to <u>1/14/61</u> and last saw her <u>alive</u> on <u>1/14/61</u> Death occurred at <u>2:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Russell Smith</i> (Degree or title) M.D.			22b. ADDRESS Carthage, Mo.		22c. DATE SIGNED 1/16/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 18, 1961	23c. NAME OF CEMETERY OR CREMATORY Sarcoxie Cemetery		23d. LOCATION (City, town, or county) (State) Sarcoxie, Mo.
24. FUNERAL DIRECTOR The Ulmer Funeral Home, Carthage, Mo.			25. DATE RECD. BY LOCAL REG. Jan. 18, 1961		26. REGISTRAR'S SIGNATURE <i>Ely Clinton</i>

JAN 25 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Edwin S. Thayer*

Licensed Embalmer No. 4955

P. O. Address *Portage, 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.