

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016322

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

UNAMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 153

FILED JUN 12 1961

1. PLACE OF DEATH a. COUNTY <u>Adair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> Length of stay in 1b <u>1 w 1</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.O. Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Appanoose</u> c. CITY OR TOWN <u>Moulton</u> 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 <u>Logan</u> Middle Last <u>Gordy</u>			4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1961</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-1900</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Schuyler Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Peter Gordy</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Ellen Watson</u>		14. NAME OF HUSBAND OR WIFE <u>Lora A. Gordy</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			17. INFORMANT Address <u>Lora A. Gordy-Moulton, Iowa</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Chronic Heart Disease (Rheumatic)</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Massive Pulmonary Edema</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ 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 <u>not at all</u> to <u>June 1, 1961</u> and last saw him alive on <u>June 1, 1961</u> Death occurred at <u>8:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) 			22b. ADDRESS <u>800 W. Jefferson, Kirksville, Mo.</u>		22c. DATE SIGNED <u>6/2/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>6-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Home</u>		23d. LOCATION (City, town, or county) (State) <u>Schuyler Co. Mo.</u>		
24. FUNERAL DIRECTOR'S NAME <u>F.P.O. Hursted & Son</u>		ADDRESS <u>(UNIONVILLE) MO</u>		25. DATE RECD. BY LOCAL REG. <u>June 8, 1961</u>	26. REGISTRAR'S SIGNATURE 		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INSTEAD OF

SHOULD READ

ITEM NO.

AUG 7 1961

JUN 22 1961

JUN 23 1961

V. H. CASNER, D.O.

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

Murle E. Dastid

Licensed Embalmer No.

3304

P. O. Address

Monroville

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.

2-1-61