

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016763
STATE FILE NUMBER

Registration District No. 387 Primary Registration District No. 5208 Registrar's No. 6

AMENDED

FILED MAY 23 1961

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Carroll											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hale,		Length of stay in 1b 39 years		c. CITY OR TOWN Hale,		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home 2 Miles S. Hale, Mo.			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) RFD		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First GLADYS Middle MAY Last WRIGHT				4. DATE OF DEATH Month May Day 18th , Year 1961.											
5. SEX F		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 2/21/1901.		9. AGE (last birthday) 60		IF UNDER 1 YEAR Months 2 Days 27		IF UNDER 24 HR Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm wife				10b. KIND OF BUSINESS OR INDUSTRY Yates, Oklahoma.				11. BIRTHPLACE (City and state or country) U. S. A.				12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME George Hoxie				13b. MOTHER'S MAIDEN NAME Nancy Jane Harrison				14. NAME OF HUSBAND OR WIFE Alfred P. Wright.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO				16. SOCIAL SECURITY NO. NO				17. INFORMANT Address Mr Alfred P. Wright, Hale, Mo. RFD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Profound Secondary Anemia DUE TO (b) Infiltration & Depression of Bone Marrow DUE TO (c) Osteoporosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										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) Tachycardia										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 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 4-4-61 to 5-19-61 and last saw her/him alive on 5-18-61 Death occurred at 7:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) Norman F. Hansen D.O.						22b. ADDRESS Hale Missouri						22c. DATE SIGNED 5-19-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 20, 1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town, or county) (State) Brookfield, Missouri.							
24. FUNERAL DIRECTOR ADDRESS Clifford W. Austin F-H Hale, Mo.				25. DATE RECD. BY LOCAL REG. MAY 20, 1961		26. REGISTRAR'S SIGNATURE Mrs. Rex Henderson									

DATE AMENDED

INSTEAD OF THIS RECORD FILE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MAY 24 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 Clyford W. Austin

Licensed Embalmer No. #3233

P. O. Address Tina, Missouri.

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.