

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020496

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

673

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED JUL 10 1961

| | | | | | | | |
|---|--|--|---|---|--|---|----------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY Buchanan | | | | a. STATE Missouri b. COUNTY Gentry | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri | | | Length of stay in lb 4 Months | c. CITY OR TOWN McFall, Missouri | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1023 Church Street | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Rural | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | Month Day Year | |
| First JENNIE Middle DRUCILLA Last TEEL | | | | June | | 30 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 July 21, 1875 | 9. AGE (last birthday) 85 | IF UNDER 1 YEAR | IF UNDER 24 HR |
| | | | | | | Months | Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (City and state of country) Gentry Co. Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Robert Deering | | | 13b. MOTHER'S MAIDEN NAME Sarah Royston | | 14. NAME OF HUSBAND OR WIFE Arron H. Teel | | |
| 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. None | 17. INFORMANT Miss Ruby Teel Address McFall, Missouri | | | |
| 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) Cerebral thrombosis | | | | | | few days | |
| DUE TO (b) Art Sclerosis | | | | | | 1 year | |
| DUE TO (c) | | | | | | | |
| 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"/> 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 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 6-28-61 to 6-28-61 and last saw her alive on 6-28-61 | | | | Death occurred at 9:20 AM m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Dr. L.H. Fuson, M.D. | | | | 22b. ADDRESS St. Joseph MO | | 22c. DATE SIGNED 7-3-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 2, 1961 | 23c. NAME OF CEMETERY OR CREMATORY McFall Cemetery | | 23d. LOCATION (City, town, or county) McFall, Missouri | | 23e. REGISTRAR'S SIGNATURE Miss Clark Standell | |
| 24. FUNERAL DIRECTOR Meierhoffer-Fleeman F.H. St. Joseph, Mo. | | | 25. DATE RECD. BY LOCAL REG. July 6, 1961 | | 26. REGISTRAR'S SIGNATURE | | |

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

L.H. Fuson, M.D.

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 Raymond A. Hooy

Licensed Embalmer No. 5147

P. O. Address St Joseph

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.