

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033553

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 166

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED SEP 25 1961

1. PLACE OF DEATH

a. COUNTY LIVINGSTON

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE Length of stay in 1b 2 WEEKS

c. CITY OR TOWN JACKSON TWP. Inside Limits Yes No

d. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL Inside Limits Yes No e. STREET ADDRESS (if outside, give location) 5 MI. N.W. on Hiway 170 Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MO. b. COUNTY LIVINGSTON

3. NAME OF DECEASED (Type or print) First NORMA Middle LUCILLE Last TIBERGHEN

4. DATE OF DEATH Month SEPTEMBER Day 11 Year 1961

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 8/9/1888 9. AGE (last birthday) 73

IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 10b. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (City and state or country) LIVINGSTON CO., MO. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME RIFE CRUMPACKER 13b. MOTHER'S MAIDEN NAME EDITH ROXY GIBBS 14. NAME OF HUSBAND OR WIFE LEE TIBERGHEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 17. INFORMANT Lee Tiberghien; R.R. #4 Chillicothe, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 weeks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Polycythemia vera + Arteriosclerosis UNKNOWN

DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of neck of Left femur

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 July 1953 to Sept. 11, 1961 and last saw her alive on Sept. 10, 1961 Death occurred at 3:50 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William L. Fair, M.D. 22b. ADDRESS Chillicothe, Mo. 22c. DATE SIGNED 9/12/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 9/13/61 23c. NAME OF CEMETERY OR CREMATORY EDGEWOOD CEMETERY 23d. LOCATION (City, town, or county) (State) CHILLICOTHE, MISSOURI

24. FUNERAL DIRECTOR ADDRESS NORMAN FUNERAL HOME: Chillicothe, Mo. 25. DATE RECD. BY LOCAL REG. Sep. 12, 1961 26. REGISTRAR'S SIGNATURE Armalee Taylor

1961 7 493 01 12 11 3

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 John P. Rodgers

Licensed Embalmer No. 4963

P. O. Address Chillicothe, 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.