

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039959

STATE FILE NUMBER

Registration District No. 372 Primary Registration District No. 4543 Registrar's No. 28

AMENDED FILED NOV 13 1961

1. PLACE OF DEATH a. COUNTY <u>Webster</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>WRIGHT</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEYMOUR</u>		Length of stay in 1b <u>6 YRS.</u>		c. CITY OR TOWN <u>MANSFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Koskovich Home</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>HATTIE</u> Middle <u>Elizabeth</u> Last <u>DENNIS</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 24 1884</u>	9. AGE (last birthday) <u>77</u>	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) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Wright County Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>HENRY DENNIS</u>			13b. MOTHER'S MAIDEN NAME <u>MARY Delilah HANKS</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>OREL DENNIS</u>		Address <u>MANSFIELD Mo.</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 Paralysis</u> DUE TO (b) <u>Thrombotic Encephalomalacia</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
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 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 <u>10/7/60</u> to <u>11/9/61</u> and last saw him alive on <u>11/8/61</u> Death occurred at <u>11:30A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. P. Sell</u> (Degree or title) <u>D.O.</u>				22b. ADDRESS <u>Seymour</u>		22c. DATE SIGNED <u>11/11/61</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>BURIAL</u>		23b. DATE <u>Nov. 12-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DENNIS</u>		23d. LOCATION (City, town or county) (State) <u>WRIGHT COUNTY Mo.</u>		
24. FUNERAL DIRECTOR <u>Max E. Miller</u>			ADDRESS <u>Mansfield Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-11-61</u>	26. REGISTRAR'S SIGNATURE <u>Gilbert Jones</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Mat E Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield, N.

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.