

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-048468**  
STATE FILE NUMBER

FILED VS DEC 21 1960  
Registration District No. 338 Primary Registration District No. 4501 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bloomfield</u>		Length of stay in 1b <u>2 Yrs.</u>	c. CITY OR TOWN <u>Bloomfield</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Yes <input 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 Middle Last <u>Sarah Mamie Tine Mayberry</u>			4. DATE OF DEATH Month Day Year <u>12 2 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>7.12.1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (City and state or country) <u>Stoddard Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Francis Blocker</u>			13b. MOTHER'S MAIDEN NAME <u>Susie Vaughn</u>		14. NAME OF HUSBAND OR WIFE <u>C.C. Mayberry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>C.C. Mayberry Bloomfield 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>Cerebral Vascular Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arteriosclerosis</u>		<u>Yes</u>			
	DUE TO (c) <u>Generalized Arteriosclerosis</u>		<u>Yes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>mild Hypertension Essential</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 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 <u>July 55 Dec. 1960</u> and last saw him alive on <u>Dec. 1, 1960</u> Death occurred at <u>Dec 2 1960</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Stephen P. Burkwood</u>			22b. ADDRESS <u>Bloomfield, Mo</u>		22c. DATE SIGNED <u>12-14-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/4/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gravel Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Stoddard Co. Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Watkins &amp; Sons Funeral Service Bloomfield Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>12-14-60</u>		26. REGISTRAR'S SIGNATURE <u>Mr. George L. Baker</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Carl M. Walker*

Licensed Embalmer No. 4964

P. O. Address *Depto*

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.