

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003043

FILED VS. JAN 19 1960

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 12

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST FRANCOIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST FRANCOIS</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FARMINGTON</b>			Length of stay in 1b		c. CITY OR TOWN <b>FARMINGTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>202 N. JACKSON</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>202 N JACKSON</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MAMIE ANN MACKLEY</b>				4. DATE OF DEATH <b>JANUARY 11 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4 1888 71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>IRONDALE MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>JOSEPH FORSHER</b>			13b. MOTHER'S MAIDEN NAME <b>MARY WALLEN</b>			14. NAME OF HUSBAND OR WIFE <b>JOHN MACKLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. GEORGE THOMAS POTOSI RT 1 MO</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute circulatory failure</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2da.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>PROLONGED RECLUMBENCY</b>						<b>4mo</b>	
DUE TO (c) <b>DIABETIC GANGRENE LEFT FOOT</b>						<b>4mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>SEVERE ARTERIOSCLEROTIC Hypertension</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <input type="checkbox"/> s.m. <input type="checkbox"/> 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 <b>1954</b> to <b>1960</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>1-11-60</b> Death occurred at <b>5:00</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>M. Tenbroeck</b> (Degree or title)				22b. ADDRESS <b>Farmington Mo.</b>		22c. DATE SIGNED <b>1-13-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>K OF P CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FARMINGTON MISSOURI</b>	
24. FUNERAL DIRECTOR <b>COZEAN FUNERAL HOME</b>		ADDRESS <b>FARMINGTON MO</b>		25. DATE RECD. BY LOCAL REG. <b>Jan 13, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>	

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

Licensed Embalmer No. 408

P. O. Address Farming

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.