# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-012315 STATE FILE NUMBER

Registration District No. 298 Primary Registration District No. 6023 Registrar's No. 32

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

1 FILED APR 10 1962

1. PLACE OF DEATH
a. COUNTY: Ray
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Knoxville
Length of stay in 1b: 1 year
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: No street address
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Ray
c. CITY OR TOWN: Knoxville — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): (Route #1, Rayville, Mo.) — Reside on Farm: Yes ☐ No ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month Day Year |
|---|---|---|---|
| JOBE | P. | TEEGARDEN | April 3, 1962 |

| 5. SEX | 6. COLOR OR RACE | 7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐ | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HR Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 12/14/1872 | 89 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Farmer | Farming | Polo, Mo. | USA |

| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
|---|---|---|
| Samuel P. Teegarden | Sarah Glenn | Rella May Teegarden |

| 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 |
|---|---|---|
| No | None | Mrs. Clifton VanBebber, Rayville, Mo. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Arteriosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

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. ☐ 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 a.m. p.m. Month, Day, Year
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 1-15-59 to 4-3-62 and last saw her/him alive on 3-30-62
Death occurred at 11:00 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.

| 22a. SIGNATURE (Degree or title) | 22b. ADDRESS | 22c. DATE SIGNED |
|---|---|---|
| Thomas B. Goodnight | Richmond Mo. | 4/4/62 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 4/3/1962 | New New Garden | Rural, Excelsior Springs, Mo. |

| 24. FUNERAL DIRECTOR ADDRESS | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE |
|---|---|---|
| Prichard Funeral Home, Excelsior Springs, Mo. | 4-5-1962 | Mabel Jackson |

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED |
|---|---|---|---|
| 1 | 0890 | | |
| 2 | 0890 | | |
| 3 | | | |
| 4 | 0 | | |
| 5 | 2 | | |
| 6 | | | |
| 7 | 0 | | |
| 8 | 2 | | |
| 9 | 4500 | | |
| 10 | | | |
| 11 | | | |
| 12 | 90-0 | | |
| 13 | 2-0 | | |

BY AFFIDAVIT OF DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

## 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,

~~X~~by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lindell Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, Mo.

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.