

TYPE/PRINT
IN
PERMANENT
BLACK INK.
FOR
INSTRUCTIONS
SEE OTHER SIDE
AND HANDBOOK.

FILED FEBRUARY 13, 2001

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

124 - 41-037795 - A

REGISTRATION DISTRICT NO. 081

REGISTRAR'S NUMBER

DELAYED

1. DECEDENT'S NAME (First, Middle, Last) Peter TANNER					2. SEX Male		3. DATE OF DEATH (Month, Day, Year) Jul 29 1941				
4. SOCIAL SECURITY NO. 99		5a. AGE - Last Birthday (Years)		5b. UNDER 1 YEAR MONTHS DAYS		5c. UNDER 1 DAY HOURS MINUTES		6. DATE OF BIRTH (Month, Day, Year) Jan 23 1842		7. BIRTHPLACE (City and State or Foreign Country) Darby Twn Pickaway OH 10	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk.			9a. PLACE OF DEATH (Check only one; see instructions on other side) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
9b. FACILITY NAME (If not institution, give street and number)					9c. CITY, TOWN, OR LOCATION OF DEATH Ridge way				9d. COUNTY OF DEATH Harrison		
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify) Married			11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) Lovica WILSON			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. RESIDENCE - STATE Missouri			13b. COUNTY Harrison			13c. CITY, TOWN, OR LOCATION Ridge way			13d. ZIP CODE 64481		
13e. STREET AND NUMBER					13i. INSIDE CITY LIMITS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13g. YEARS AT PRESENT ADDRESS <input type="checkbox"/> Under 5 <input type="checkbox"/> 5-9 <input type="checkbox"/> 10-19 <input checked="" type="checkbox"/> 20 or more				
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:					15. RACE - American Indian, Black, White, etc. (Specify) White			16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
17. FATHER'S NAME (First, Middle, Last) David TANNER					18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine GEORGE						
19a. INFORMANT'S NAME (Type/Print) Walter Lee CLAPHAM					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 6th Ave East #9 Sheridan WY 82801-6276						
20a. BURIAL, CREMATION, OTHER (Specify) Burial			20b. DATE OF DISPOSITION (Month, Day, Year) Jul 31 1941		20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Yankoo Ridge Cemetery			20d. LOCATION (City or Town, State) Ridge way Harrison County Missouri			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH J P Ragan					22a. NAME AND ADDRESS OF FACILITY Acting Mortician			22b. FUNERAL ESTABLISHMENT LICENSE NUMBER			
23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE → Old Age (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST a. OLD AGE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk.		25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY M	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		27e. DESCRIBE HOW INJURY OCCURRED		
27f. PLACE OF INJURY - At home, farm street, factory, office building, etc. (specify)					27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
28a. (Specify) <input type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> MEDICAL EXAMINER/CORONER			28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) ▶				28c. DATE SIGNED (Month, Day, Year)		28d. TIME OF DEATH M		
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) J P Ragan Acting Mortician					29b. MO. LICENSE NUMBER		30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input type="checkbox"/> No				
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			32. REGISTRAR'S SIGNATURE Garland H. Lund				33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) February 13, 2001				

STATEMENT FROM WALTER CLAPHAM AND A COPY OF JULY 29, 1941 IN FOR USE BY PHYSICIAN OR INSTITUTION

PARENTS

INFORMANT

DISPOSITION

NOTARIZED COPY OF THE TOMB PASSE AWAY

CAUSE OF DEATH

FILED ON THE BASIS OF THE OBITUARY OF CLAPHAM. A PICTURE OF THE TOMB PASSE AWAY. Harrison Co. Mo.

CERTIFIER

DO NOT WRITE ON THIS STUB	7-cy	12a	23u	27g-co
	9a	13e	23-sc1	29g-cy
	9b	13b	27-sc2	29a
	9c	14	27e-f	29b
	12b	15	27g-st	

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 _____ Signed _____
 Signature of Student Embalmer

Licensed Embalmer No. _____

NAME OF DECEDENT _____ P.O. Address _____

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.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the chain of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

EXAMPLE OF PHYSICIAN CERTIFICATION:	23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death	
	IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	a.	Rupture of myocardium DUE TO (OR AS A CONSEQUENCE OF):		Mins	
CAUSE OF DEATH		b.	Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):		6 days	
		c.	Chronic ischemic heart disease DUE TO (OR AS A CONSEQUENCE OF):		5 years	
		d.				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Chronic obstructive pulmonary disease, smoking				24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27d. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27e. DESCRIBE HOW INJURY OCCURRED	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

EXAMPLE OF MEDICAL EXAMINER OR CORONER	23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death	
	IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	a.	Cerebral laceration DUE TO (OR AS A CONSEQUENCE OF):		10 mins.	
CAUSE OF DEATH		b.	Open skull fracture DUE TO (OR AS A CONSEQUENCE OF):		10 mins.	
		c.	Automobile accident DUE TO (OR AS A CONSEQUENCE OF):		10 mins.	
		d.				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27d. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK.	27e. DESCRIBE HOW INJURY OCCURRED	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) Street				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) Route 4, Jefferson City, Missouri		