

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047018
STATE FILE NUMBER

360
Registration District No. _____ Primary Registration District No. 6225 Registrar's No. 178

FILED DEC 30 1958

300
1-57

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON TOWN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>unknown</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSP # 3</u> Length of stay in lb <u>1 MONTH, 4 DAYS</u>		d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>GEORGE</u> _____ <u>PACKARD</u>			4. DATE OF DEATH Month Day Year <u>DEC. 14 1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		9b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>unknown</u>
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? _____		13a. FATHER'S NAME _____ 13b. MOTHER'S MAIDEN NAME _____	
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>UNKNOWN</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>HOSP. RECORD STATE HOSP # 3 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>CORONARY OCCLUSION</u> DUE TO (b) <u>GENERALIZED ART. SCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>AMPUTATE LEG. POSITIVE SEROLOGIC VDRL</u>			INTERVAL BETWEEN ONSET AND DEATH <u>FEW MINUTES</u> <u>MONTHS YEARS</u>
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 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>NOV 12 1958</u> to <u>DEC. 14 1958</u> and last saw him alive on <u>DEC. 17 1958</u> Death occurred at <u>10:35 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edmund M. Thompson M.D.</u>		22b. ADDRESS <u>STATE HOSP # 3 MO</u>	
22c. DATE SIGNED <u>12-14-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>12-14-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Neosho, Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Neosho, Cemetery MO</u>		(State) _____	
24. FUNERAL DIRECTOR <u>Thompson Funeral Home Neosho, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-22-58</u>	
26. REGISTRAR'S SIGNATURE <u>Arma E. Cherry</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

FEB 18 1954

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 *Percy F. Melstee*

Licensed Embalmer No. *4805*

P. O. Address *Nevada, 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.