

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 7 1961

-61-002280

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Miller</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Iberia</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u> c. CITY OR TOWN <u>Iberia</u> Inside Limits Yes ☒ No ☐ d. STREET ADDRESS (If outside, give location) <u>Lombard, St.</u> Reside on Farm Yes ☐ No ☒							
3. NAME OF DECEASED First Middle Last <u>Clayton Elsworth Ambrose</u>				4. DATE OF DEATH Month Day Year <u>January 28 1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐		8. DATE OF BIRTH <u>11/19/92</u>		9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Spring Garden, Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Ambrose</u>				13b. MOTHER'S MAIDEN NAME <u>Ida Musick</u>				14. NAME OF HUSBAND OR WIFE <u>Opal R. Ambrose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>497-16-3502</u>		17. INFORMANT <u>Ida Ambrose</u> Address <u>Iberia, 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 Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
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 <u>1960</u> to <u>1/28/61</u> and last saw him alive on <u>1/27/61</u> Death occurred at <u>2:15a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Wm. A. Gould D.O.</u>						22b. ADDRESS <u>Iberia Mo</u>				22c. DATE SIGNED <u>1/30/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Iberia Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Iberia, Missouri</u>			
24. FUNERAL DIRECTOR <u>Ida Ambrose</u> ADDRESS <u>Iberia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Jan. 30 1961</u>		26. REGISTRAR'S SIGNATURE <u>Jessie Perkins</u>					

AUG 5 1962

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 J. A. Humpfrey

Licensed Embalmer No. 4772

P. O. Address Iberia, 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.