

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-004562

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 127

AMENDED

FILED VS MAR 8 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PULASKI</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		c. CITY OR TOWN <u>WAYNESVILLE</u>	
Length of stay in 1b <u>16 DAYS</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEDICAL CENTER</u>		d. STREET ADDRESS (If outside, give location) <u>GENERAL DELIVERY</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOAN CLAYTON ICE</u>			4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>61</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-35</u>
9. AGE (last birthday) <u>25</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>OSAGE IOWA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>EDWARD Charles Clayton</u>	
13b. MOTHER'S MAIDEN NAME <u>BERTHA DOPP</u>		14. NAME OF HUSBAND OR WIFE <u>DONALD PAUL ICE</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>UNKNOWN</u>	
17. INFIRMANT Address <u>HOSPITAL RECORD COLUMBIA 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>Ventricular Fibrillation due to dilatation of left ventricle</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>acute myocardial infarction, initial infarction, + stenosis</u> <u>13 years</u>			
DUE TO (c) <u>Rheumatic Fever</u> <u>13 years</u>			
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ 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 <u>2-8-61</u> , to <u>2-24-61</u> and last saw her alive on <u>2-24-61</u> Death occurred at <u>3:37</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Earl J. Waffle, Jr., M.D.</u>		22b. ADDRESS <u>U. of Mo. Medical Center</u>	22c. DATE SIGNED <u>2-24-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>2-25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osage Cem Tarab Co.</u>	23d. LOCATION (City, town, or county) (State) <u>HOUSTON MISSOURI</u>
24. FUNERAL DIRECTOR ADDRESS <u>PARKER FUNERAL SERVICE</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 25, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

MAR 21 1967

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 George A. Kerby

Licensed Embalmer No. 4752

P. O. Address Columbia, Md

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.