

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005193

STATE FILE NUMBER

AMENDED

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 11

FILED VS MAR 6 1961

1. PLACE OF DEATH a. COUNTY Holt		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Holt	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maitland	Length of stay in 1b 10 yrs	c. CITY OR TOWN Maitland	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 1/4 mi s w maitland		d. STREET ADDRESS (If outside, give location) 1 1/4 mi s w Maitland	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FRED Middle A Last JUNE	4. DATE OF DEATH Month 2 Day 26 Year 1961
---	---

5. SEX male	6. COLOR OR RACE cau	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1,4,1893	9. AGE (last birthday) 68	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) farmer	10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and state or country) Maryville, Mo	12. CITIZEN OF WHAT COUNTRY USA
--	---	--	---

13a. FATHER'S NAME John L. June	13b. MOTHER'S MAIDEN NAME Mary Frances Bigley	14. NAME OF HUSBAND OR WIFE Mildred G. June
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Mrs Mildred G. June, Maitland, Mo.
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 4 weeks
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 _____ 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 Jan 3/1961 to Feb 26/1961 and last saw ^{her}him alive on Feb 26/1961
Death occurred at 3.30 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Bruce McRae D.O.	22b. ADDRESS Mound City Mo	22c. DATE SIGNED 2/28/61
--	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2,28,1961	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) Maryville, Mo.
--	-------------------------------	--	--

24. FUNERAL DIRECTOR Atchison Funeral Home, Maryville, Mo.	ADDRESS _____	25. DATE RECD. BY LOCAL REG. 2/28/1961	26. REGISTRAR'S SIGNATURE Jamett H. ...
--	---------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 M. Cleburne

Licensed Embalmer No.

5114

P. O. Address

Maryville

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.