

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005704

STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 37

AMENDED

FILED VS MAR 6 1961

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webb City</b>		Length of stay in 1b <b>6 Months</b>	c. CITY OR TOWN <b>Webb City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>719 S. Hall</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>719 So. Hall</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Greenleaf</b> Last <b>Rose</b>			4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1961</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-83</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>25</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>James H. Rose</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Leonard Rose, Rt. 1 Joplin, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		<b>8 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic heart disease</b>	<b>5 months</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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>	Month <b></b> Day <b></b> Year <b></b>
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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 <b>Jasper</b>	COUNTY <b>Jasper</b>	STATE <b>Mo.</b>
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21. I attended the deceased from **10-4-50** to **2-25-51** and last saw <sup>her</sup>him alive on **2-25-51**  
Death occurred at **2:15 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>James V. Fleckerty, M.D.</b>	22b. ADDRESS <b>319 W. Main St., Cartersville, Mo.</b>	22c. DATE SIGNED <b>2-27-51</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-1-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Jasperfield, Mo.</b>
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24. FUNERAL DIRECTOR <b>Johnston-Simpson, Webb City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-28-61</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Madeline Surtz</b>
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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

**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 Jack C. Simpson  
Licensed Embalmer No. 4647  
P. O. Address Webb City

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.