MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-008190
STATE FILE NUMBER

Registration District No. 99 Primary Registration District No. 4168 Registrar's No. 14

AMENDED

FILED MAR 28 1961

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: DeKalb
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: maysville
Length of stay in 1b: life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Sunset rest home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY: DeKalb
c. CITY OR TOWN: Maysville
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): in town
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Kate Middle: Last: Dice
4. DATE OF DEATH Month Day Year: 3-11-61
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12-15-1882
9. AGE (last birthday): 78
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): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: George Dice
13b. MOTHER'S MAIDEN NAME: Sarah Wand
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Allie Truex Address: Maysville Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs.
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. ☐ Yes ☐ No ☐ Unknown

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 1942, to 3/11/61 and last saw her/him alive on 3/10/61
Death occurred at 6:30 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Harold Fowler (Degree or title) D.O.
22b. ADDRESS: Maysville Mo
22c. DATE SIGNED: 3/12/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-12-61
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn
23d. LOCATION (City, town, or county) (State): Maysville Mo

24. FUNERAL DIRECTOR: John Boon ADDRESS: Maysville Mo
25. DATE RECD. BY LOCAL REG.: 3-21-61
26. REGISTRAR'S SIGNATURE: Gertie E. Davidson

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. 3933

P. O. Address Maysville 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.