

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318 Primary Registration District No. 1003 Registrar's No. 3261-61-011210 STATE FILE NUMBER

Registration District No. FILED APR 14 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wyoming b. COUNTY Albany		c. CITY OR TOWN Laramie		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1303 South 13th				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle L. Last MCGILL						4. DATE OF DEATH Month APRIL Day 6 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-12-1908		9. AGE (last birthday) 53		IF UNDER 1 YEAR Months Days 2 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Indianapolis-Indiana		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME C. R. Edmonds				13b. MOTHER'S MAIDEN NAME Mary Keiper				14. NAME OF HUSBAND OR WIFE Vernie J. McGill			
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. None		17. INFORMANT Vernie J. McGill, Laramie WYO Address 1303 So 13th St					
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) POST-OPERATIVE HEMORRHAGE FROM JUGULAR VEIN										IMMEDIATE	
DUE TO (b) RADICAL RESECTION OF LARYNX, PHARYNX AND UPPER ESOPHAGUS										9 DAYS	
DUE TO (c) CARCINOMA OF PHARYNX 148x										MONTHS	
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 checked="" type="checkbox"/> N- <input 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 MARCH 23, 1961 to APRIL 6, 1961 and last saw her/him alive on APRIL 6, 1961 Death occurred at 8:10 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) C. D. Williams, M.D.						22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 4/6/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-6-61		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery			23d. LOCATION (City, town, or county) Laramie, Wyoming			(State)	
24. FUNERAL DIRECTOR Nieburg & Ditt Inc Washington, Mo				ADDRESS		25. DATE RECD. BY LOCAL REG. APR 6 1961		26. REGISTRAR'S SIGNATURE Loan Smith M.D.			

STATEMENT BY LICENSED EMBALMER

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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 Jerome F. Dvorak

Licensed Embalmer No. 4507

P. O. Address Washington

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.