

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016188
STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 39

AMENDED

FILED MAY 8 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		c. CITY OR TOWN <u>Osgood</u>	
Length of stay in 1b <u>1 wk</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SCM Hospital</u>		d. STREET ADDRESS (if outside, give location)	
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 First Middle Last <u>MABEL ANN HART</u>			4. DATE OF DEATH Month Day Year <u>4-25-1961</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>9-18-1885</u>
9. AGE (last birthday) <u>75</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)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John Frost</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy Morgan</u>		14. NAME OF HUSBAND OR WIFE <u>A.H. Hart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT Address <u>A.H. Hart Osgood 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>Acute Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
DUE TO (b) <u>Lobar pneumonia</u>			<u>18 days</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>senile dementia</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>Jan. 10 1948</u> to <u>Apr. 25 1961</u> and last saw her/him alive on <u>Apr. 25 1961</u> Death occurred at <u>5:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>DD.</u>		22b. ADDRESS <u>Newtown, Mo.</u>	
22c. DATE SIGNED <u>4/26/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-28-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Camp Ground Cem.</u>	23d. LOCATION (City, town, or county) <u>Osgood Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Payne Funeral Home Salt Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-29-61</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beebe</u>			

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 PK Payne J

Licensed Embalmer No. 3400

P. O. Address Salt

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.