

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-016356
STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 54

AMENDED

FILED MAY 16 1961

1. PLACE OF DEATH a. COUNTY <u>ATCHISON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FAIRFAX</u>		c. CITY OR TOWN <u>FORTESCUE</u>	
Length of stay in 1b <u>6 HOURS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Hosp.</u>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>VARVEL</u> Last _____			4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>FORTESCUE, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>WASHINGTON VARVEL</u>		13b. MOTHER'S MAIDEN NAME <u>JARAH J. ABBOTT</u>	
14. NAME OF HUSBAND OR WIFE <u>FLORENCE VARVEL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>HARRY VARVEL, CRAIG Mo.</u>		Address _____		_____	

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>Cerebral Anoxia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
DUE TO (b) <u>Cerebral Vascular Accident</u>			
DUE TO (c) <u>Cerebral Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a) <u>Generalized Arteriosclerosis</u>			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.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Mound City, Mo.</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>July 1959</u> to <u>May 1, 1961</u> and last saw <u>him</u> alive on <u>May 8, 1961</u> Death occurred at <u>12:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>James Humphrey M.D.</u>	22b. ADDRESS <u>Mound City, Mo.</u>	22c. DATE SIGNED <u>5/8/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-10-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest City, Mo.</u>
23d. LOCATION (City, town, or county) <u>Forest City, Mo.</u>		(State) _____

24. FUNERAL DIRECTOR <u>James H. Crawford</u>	ADDRESS <u>Mound City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 17, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Therwin N. Schuler</u>
--	-----------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

MAY 23 1961

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

James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound 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.