

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-020266

STATE FILE NUMBER

AMENDED

Filed and Dist. No. 1-1-1961 Primary Registration District No. _____ Registrar's No. 75

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Atchison				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Atchison									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rock Port.		Length of stay in 1b		c. CITY OR TOWN Rock Port.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION none			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) none		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Rex Middle _____ Last Moore				4. DATE OF DEATH Month 7 Day 2 Year 1961									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-31-1880		9. AGE (last birthday) 81		IF UNDER 1 YEAR Months 3 Days 1 Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Decorator		11. BIRTHPLACE (City and state or county) Morristown, Tenn.		12. CITIZEN OF WHAT COUNTRY US					
13a. FATHER'S NAME John Moore				13b. MOTHER'S MAIDEN NAME Mary Jane McCoy				14. NAME OF HUSBAND OR WIFE none					
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 Miss Grace Updike		Address Rock Port.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ASHD DUE TO (c) generalized arterosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus										INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years years			
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 6/15/61 to 7/2/61 and last saw her/him alive on 7/2/61 Death occurred at 3:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) John M. Wanamaker, M.D.						22b. ADDRESS Rock Port, Mo.			22c. DATE SIGNED 7/3/61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-5-1961		23c. NAME OF CEMETERY OR CREMATORY English Grove Cem.		23d. LOCATION (City, town, or county) Fairfax, Mo.		(State)					
24. FUNERAL DIRECTOR Bartholomew Mortuary, Rock Port.					25. DATE RECD. BY LOCAL REG. July 4, 1961		26. REGISTRAR'S SIGNATURE Tharvin N. Schoeler						

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 Geat Bachelorew

Licensed Embalmer No. 3173

P. O. Address Rock Falls

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.