

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020827
STATE FILE NUMBER

AMENDED

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 57

FILED JUN 21 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Dent</u>		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Springcreek</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Dent</u>	
Length of stay in 1b <u>5 yrs</u>		c. CITY OR TOWN <u>Salem</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>rt 1</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at residence</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Joseph</u>		Middle <u>J</u>		Last <u>Recla</u>		Month <u>June</u> Day <u>17</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>10-3-90</u>	9. AGE (last birthday) <u>70</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		11. BIRTHPLACE (City and state or country) <u>not available</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Joseph J Recla</u>			13b. MOTHER'S MAIDEN NAME <u>not available</u>			14. NAME OF HUSBAND OR WIFE <u>not available</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>X</u>		17. INFORMANT Address <u>Irene Sumpter Rt 1 Salem Mo</u>			
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) <u>Apparently due to natural causes</u> <u>(by Coroner, H. Powell, D.O.)</u>							
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input 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 _____ to _____ and last saw ^{her} him alive on _____ Death occurred at <u>10:00A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Martin Hart</u> (Degree or title) <u>Registrar</u>				22b. ADDRESS <u>Salem Missouri</u>		22c. DATE SIGNED <u>6/17/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Salem Mo</u>	
24. FUNERAL DIRECTOR <u>Spencer Funeral Home Inc</u>		ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>6/17/61</u>		26. REGISTRAR'S SIGNATURE <u>M. M. Hart, M.D. Inc</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

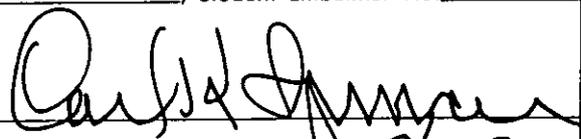
JUN 27 1961

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 

Licensed Embalmer No. 9370

P. O. Address Deer Creek, W. Va.

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.