

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-021868

AMENDED

Registration District No. 700 Primary Registration District No. 3041 Registrar's No. 106

STATE FILE NUMBER

FILED JUL 6 1961

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

c. CITY
OR TOWN

Inside Limits

Yes ☐ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

4. DATE
OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. Married

Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

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)

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

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)

Medullary Paralysis

INTERVAL BETWEEN ONSET AND DEATH

1 hour

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Thrombotic Encephalomalacia with Cerebral

Hemorrhage

5 days

DUE TO (c)

Arteriosclerosis

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Paralysis agitans

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

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 ☐
NOT WHILE AT WORK ☐

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 June 6, 1961 to June 21, 1961 and last saw her alive on June 20, 1961
Death occurred at 5:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

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

[Handwritten Signature]

Licensed Embalmer No. 1961

P. O. Address Reverie Ave

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.