

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026354

STATE FILE NUMBER

AMENDED

Registration District No. 394 Primary Registration District No. \_\_\_\_\_ Registrar's No. 102

FILED AUG 1 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |   |   |  |   |       |
|---|---|---|---|--|---|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Reynolds Co</u>   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Reynolds</u> |  |   |       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Black typ</u>   |   | Length of stay in 1b<br><u>70 yrs</u>   | c. CITY OR TOWN <u>Black</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>at residence</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>Cates route</u>   |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |       |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John Francis</u> Middle <u>Volner</u> Last _____  |   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>15</u> Year <u>1961</u>  |  |   |       |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>1010-74</u>   | 9. AGE (last birthday) <u>86</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____  |       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>farmer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>general</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Reynolds Co Mo</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U S A</u>   |       |
| 13a. FATHER'S NAME<br><u>William F Volner</u>   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Rebecca Trolinger</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Lucy Jane Montgomery</u>   |   |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   | 16. SOCIAL SECURITY NO. <u>X</u>  | 17. INFORMANT<br><u>Lucy Jane Volner</u>  |   | Address<br><u>Black Mo</u>   |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart disease (4151)</u>   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |       |
| 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.<br><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<br>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>5/27/47</u> to <u>7/15/61</u> and last saw <sup>her</sup> him alive on <u>8/23/60</u><br>Death occurred at <u>4:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |  |   |       |
| 22a. SIGNATURE<br><u>Martha M. [Signature]</u> (Degree or title)  |   |   | 22b. ADDRESS<br><u>Salem Missouri</u>   |  | 22c. DATE SIGNED<br><u>7/21/61</u> (State)  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  | 23b. DATE<br><u>7-19-61</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Myers Cem</u>  |   | 23d. LOCATION (City, town, or county)<br><u>Reynolds Co Mo</u>   |   |       |
| 24. FUNERAL DIRECTOR<br><u>Spencer Fvneral Home Inc</u> ADDRESS   |   | 25. DATE RECD. BY LOCAL REG.<br><u>7-25-1961</u>  | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</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 Carl H. Johnson

Licensed Embalmer No. 2370

P. O. Address Salem, N.J.

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.