

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028571

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 331

STATE FILE NUMBER

FILED AUG 21 1961

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CAPE-GIR</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ALLENVILLE</u>	Length of stay in 1b <u>30 ym.</u>	c. CITY OR TOWN <u>ALLENVILLE</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS JEFFERSON DEVORE</u>			4. DATE OF DEATH Month Day Year <u>AUG 11 1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1875</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>1 2</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PUBLIC WORK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SAW MILL</u>	11. BIRTHPLACE (City and state or country) <u>LAKEIN MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN H. DEVORE</u>	13b. MOTHER'S MAIDEN NAME <u>SUSAN SCHULTZ</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. T. J. DEVORE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <u>4</u>	17. INFORMANT <u>OTTO DEVORE-CAPE GIRARD DEAG</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 <u>5 days</u>
IMMEDIATE CAUSE (a)	<u>virus pneumonia</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>advanced age</u>	
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 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.) <u>none</u>
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		

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>none</u>	20f. CITY, TOWN, OR LOCATION <u>Delta MO</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
21. I attended the deceased from <u>Aug 6 '61</u> to <u>Aug 11 '61</u> and last saw him alive on <u>Aug 10 1961</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge from the causes stated.				

22a. SIGNATURE <u>W. J. Savault M.D.</u>	(Degree or title)	22b. ADDRESS <u>Delta MO</u>	22c. DATE SIGNED <u>Aug 15 '61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG. 14-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>	23d. LOCATION (City, town, or county) (State) <u>ADVANCE MO</u>
24. FUNERAL DIRECTOR <u>STUBBS' FUNERAL HOME</u>	ADDRESS <u>MO</u>	25. DATE RECD. BY LOCAL REG. <u>8-17-61</u>	26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Eugene L. Stubbins

Licensed Embalmer No. 5012

P. O. Address Chaffee, Ala.

AUG 24 1961

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.