

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-029881

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 170

FILED SEP 6 1961

1. PLACE OF DEATH a. COUNTY Jasper			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jasper		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 40 yrs	c. CITY OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 316 Bellaire	
3. NAME OF DECEASED (Type or print) First Middle Last MAYME LAVERN VAWTER			4. DATE OF DEATH Month Day Year August 30, 1961		
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-14-85	9. AGE (last birthday) 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Lavaca, Arkansas	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Thomas J. Wright		13b. MOTHER'S MAIDEN NAME Jennie Pain		14. NAME OF HUSBAND OR WIFE Otis E. Vawter	
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 Address O.E. Vawter, 316 Bellaire, Carthage Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia with respiratory failure					INTERVAL BETWEEN ONSET AND DEATH 45 hrs.
DUE TO (b) Ventricular Fibrillation occurred during operation for fracture of left femur-					45 hrs.
DUE TO (c) Fracture left femur					88 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture left femur					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 checked="" 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.) Fell while walking in living room			
20c. TIME OF INJURY Hour Minute 6:00 30	Month, Day, Year 8/26/61				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Her home.	20f. CITY, TOWN, OR LOCATION Carthage,	COUNTY Jasper,	STATE Missouri	
21. I attended the deceased from 1938, to 8-30-61 and last saw her alive on 8-30-61 Death occurred at 9:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>W Russell Smith</i>		(Degree or title) MD	22b. ADDRESS Carthage, Mo	22c. DATE SIGNED 8-31-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9-1-61	23c. NAME OF CEMETERY OR CREMATORY Park Cemetery	23d. LOCATION (City, town, or county) Carthage, Mo		
24. FUNERAL DIRECTOR Knell Mortuary, Carthage, Mo		ADDRESS	25. DATE RECD. BY LOCAL REG. 9-1-61	26. REGISTRAR'S SIGNATURE <i>W Russell Smith</i>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.

JAN 16 1962

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 Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, Mo

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.