

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031642

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 300 Primary Registration District No. 6225 Registrar's No. 131

AMENDED

**FILED AUG 22 1961**

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Newton</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in lb <u>18 days</u>	c. CITY OR TOWN <u>Neosho</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. # 3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>333 W. Adams</u>
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Whorton</u> Last <u>James</u>			4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>61</u>			
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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>5-26-63</u>	9. AGE (last birthday) <u>98</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Paducah, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>none</u>	13b. MOTHER'S MAIDEN NAME <u>none</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Elizabeth James</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Records</u> Address <u>State Hospital Nevada Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</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) <u>Chronic Brain Syndrome assoc. with Cerebral Arteriosclerosis</u>		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
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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.)
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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 _____
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21. I attended the deceased from <u>7-20-61</u> to <u>8-7-61</u> and last saw him alive on <u>8-7-61</u> . Death occurred at <u>11:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. Combs</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Nevada Mo</u>	22c. DATE SIGNED <u>8-7-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-10-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gibson</u>	23d. LOCATION (City, town, or county) (State) <u>Neosho Missouri</u>
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24. FUNERAL DIRECTOR <u>Thompson Funeral Home, Neosho Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-14-1961</u>	26. REGISTRAR'S SIGNATURE <u>Anna S. Jurek</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Ray Ireland

Licensed Embalmer No. 5052

P. O. Address Nevada, 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.