

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

937-61-032475
STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 937-61-032475

FILED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>2 WEEKS</u>	c. CITY OR TOWN <u>Buffalo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Protestant Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.R. 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILFRED - Choate</u>			4. DATE OF DEATH Month Day Year <u>October 4, 1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</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>Apr 27, 1911</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Polk County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>M. M. Choate</u>	13b. MOTHER'S MAIDEN NAME <u>Geatie CLAVE</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth Choate</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>unknown.</u>	17. INFORMANT <u>Ruth Choate</u> Address <u>Buffalo Mo.</u>

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>Ruptured cerebral aneurysm</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 h</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)		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 checked="" type="checkbox"/> NO <input 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 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>9-8-61</u> to <u>10-4-61</u> and last saw her/him alive on <u>10-3-61</u> Death occurred at <u>4:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>W. S. [Signature]</u>	22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>10-5-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 9, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Prairie Cem.</u>
23d. LOCATION (City, town, or county) <u>Polk County, Missouri</u>		

24. FUNERAL DIRECTOR ADDRESS <u>Montgomery Funeral Home Buffalo, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-6-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u>
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(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 Wesley H. Ueta

Licensed Embalmer No. 5003

P. O. Address Buffalo, 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.