

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035793

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 3003 Primary Registration District No. 3003 Registrar's No. 147

1. PLACE OF DEATH a. COUNTY BARRY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY BARRY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MONETT		Length of stay in 1b 8 days	c. CITY OR TOWN CASSVILLE Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. VINCENT'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1107 Fair St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JANE Middle PEARL Last HENSLE			4. DATE OF DEATH Month Nov. Day 3 Year 1961		
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5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/6/08	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife	10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (City and state or country) St. Park, Kans	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Frank Affalter	13b. MOTHER'S MAIDEN NAME Alice Pumphrey	14. NAME OF HUSBAND OR WIFE
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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) no	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital records	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary Edema		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Congestive Heart Failure	
DUE TO (c) Rheumatic Fever, old		
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 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
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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 **Oct 1 61** to **Nov 3, 1961** and last saw her **10/2/61** and last saw him alive on **10/2/61**
Death occurred at **9:05** **A**.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Charles H Price MD	22b. ADDRESS Cassville, Mo.	22c. DATE SIGNED 11-3-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11/3/61	23c. NAME OF CEMETERY OR CREMATORY City	23d. LOCATION (City, town, or county) Mission, Kans.	(State)
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24. FUNERAL DIRECTOR Doyle E. Williamson, Cassville, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 11-4-61	26. REGISTRAR'S SIGNATURE Mrs P. N. Cook
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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
 SHOULD READ
 BY AFFIDAVIT OF

NOV 8 1961

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 *Dwight E. Williams*

Licensed Embalmer No. 4883

P. O. Address Cassville, 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.