

MISSOURI DIVISION OF HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

FILED OCT 16 1961

Registration District No.

3006

Registrar's No.

609

-61-035840

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dart</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in lb <u>45 days</u>		c. CITY OR TOWN <u>Salem</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>University Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Knox Nursing Home</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MATTIE</u> Middle <u>CUSTER</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-82</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Yorks Neb</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S</u>	
13a. FATHER'S NAME <u>Cabuan C. Custer</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah McFadden</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>None</u>		17. INFORMANT Address <u>University Medical Records Columbia 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>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Recent surgery (6 wks.) on hip.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u>8/25/61</u>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u> </u>			COUNTY <u> </u>		STATE <u> </u>	
21. I attended the deceased from <u>8/25/61</u> to <u>10/9/61</u> and last saw her/him alive on <u>10/9/61</u> Death occurred at <u>5:05</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <u>Earl J. Wiegler, Jr. M.D.</u>			
22b. ADDRESS <u>U. of Mo. Medical Center</u>				22c. DATE SIGNED <u>10-9-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10-9-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Eminence Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Mountain View Mo</u>			
24. FUNERAL DIRECTOR <u>PARKER FUNERAL SERVICE MISSOURI</u>		ADDRESS <u>COLUMBIA</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 10, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 17 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 J. W. Phillips
Licensed Embalmer No. 4897

P. O. Address Columbia 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.