

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039866

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4513 Registrar's No. 97

AMENDED

FILED NOV 14 1961

|  |  |  |  |   |  |  |  |  |
|--|--|--|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Sullivan</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Res. date before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u> |  |  |  |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Green Castle</u>  |  | Length of stay in 1b <u>Life</u>   |  | c. CITY OR TOWN <u>Green Castle</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>Own home</u>  |  |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (if outside, give location) <u>No street address</u> |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle ----- Last <u>Muir</u>   |  |  | 4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1961</u>   |   |  |  |  |  |
| 5. SEX <u>Male</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>5/10/1875</u>   | 9. AGE (last birthday) <u>86</u>                                       | IF UNDER 1 YEAR Months _____ Days _____  | IF UNDER 24 HR Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith</u>  |  | 11. BIRTHPLACE (City and state or country) <u>Memphis, Missouri</u>   |  | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |  |
| 13a. FATHER'S NAME <u>Oliver Perry Muir</u>  |  |  | 13b. MOTHER'S MAIDEN NAME <u>Melissa Jane Kight</u>                    |   |  | 14. NAME OF HUSBAND OR WIFE <u>Ester S. Muir</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>Len Muir, Green Castle, Mo.</u>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO (b) <u>Chronic Dilatation of Heart</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>  |  |  |
| 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.<br><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.)  |  |  |  |  |
| 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>1950</u> to <u>Nov 7-61</u> and last saw <sup>her</sup> him alive on <u>Nov 1-1961</u> . Death occurred at _____ a _____ m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |  |  |   |  |  |  |  |
| 22a. SIGNATURE <u>H. Garrison</u> (Degree or title) <u>MD</u>  |  |  |  | 22b. ADDRESS <u>Nowinger, Mo.</u>   |  | 22c. DATE SIGNED <u>11-5-61</u>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE <u>11/9/1961</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Castle Cemetery</u>        |   | 23d. LOCATION (City, town, or county) (State) <u>Green Castle, Mo.</u> |  |  |  |
| 24. FUNERAL DIRECTOR <u>Glenn E. Keats &amp; Son, Green City, Mo.</u> ADDRESS _____  |  |  | 25. DATE RECD. BY LOCAL REG. <u>11-9-61</u>                            |   | 26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>                    |  |  |  |

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, 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.