

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-040265

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 428

AMENDED

FILED DEC 11 1961

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WYAND	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		c. CITY OR TOWN WAPPA PELLO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION POPLAR BLUFF HOSPITAL		d. STREET ADDRESS (If outside, give location) CLAYS CABINS	

3. NAME OF DECEASED (Type or print) First JAMES Middle WILLIAM Last FILKEY			4. DATE OF DEATH Month DEC Day 2 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-9-1904	9. AGE (last birthday) 77	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LATHING CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (City and state or country) MT. CARMEL ILL		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME WILLIAM HENRY FILKEY			13b. MOTHER'S MAIDEN NAME MARY CATHERINE WALTERS		14. NAME OF HUSBAND OR WIFE EVA MAY FILKEY	
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.		17. INFORMANT EVA MAY FILKEY Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
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.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 11-18-61 to 12-2-61 and last saw ^{her}him alive on 12-2-61
Death occurred at 6:35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James H. Overmyer M.D.		22b. ADDRESS 215 Oak Street Poplar Bluff, Mo.		22c. DATE SIGNED 12/6/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE DEC 4 1961	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK		23d. LOCATION (City, town, or county) (State) ST LOUIS MO.	
24. FUNERAL DIRECTOR GISH FUNERAL HOME ADDRESS PIEDMONT MO.		25. DATE RECD. BY LOCAL REG. 12/8/1961	26. REGISTRAR'S SIGNATURE Shelma Graham		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

