

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040731

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 700 Registrar's No. 1107B STATE FILE NUMBER

AMENDED

FILED NOV 24 1961

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>1 MONTH</u>	c. CITY OR TOWN <u>SEYMOUR</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>ST. JOHNS HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>SEYMOUR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MAUD MAE JACOBSEN</u>			4. DATE OF DEATH Month Day Year <u>NOV- 14- 1961</u>		
5. SEX <u>FEMALE</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>MAR. 6, 1886</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>WHITEHOUSE, OHIO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>DAVID MINNER</u>		13b. MOTHER'S MAIDEN NAME <u>HANNAH SACHES</u>		14. NAME OF HUSBAND OR WIFE <u>DEC - MRS. ARVIN COTTON SEYMOUR, MO.</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>MRS. ARVIN COTTON SEYMOUR, MO.</u>		

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) <u>Cerebral thrombosis</u>		<u>1 mo</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>		<u>unk</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>		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 checked="" 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>10/18/61</u> to <u>11/14/61</u> and last saw her/him alive on <u>11/14/61</u> Death occurred at <u>4 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Andrew Olsen</u>		22b. ADDRESS <u>609 Cherry Springfield Mo</u>	22c. DATE SIGNED <u>11/18/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-18-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR MASONIC</u>	23d. LOCATION (City, town, county) (State) <u>WEBSTER Co., MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Robert Bergman Seymour, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-21-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meets</u>

DATE AMENDED

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Marzfield 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.