

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-043290

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 524 Primary Registration District No. 3072 Registrar's No. 210

AMENDED

FILED NOV 20 1961

1. PLACE OF DEATH a. COUNTY <b>Saline</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b		c. CITY OR TOWN <b>Olean</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbons Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>no street address</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>LOWRY</b> Last <b>VANPOOL</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> , Year <b>1961</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/6/79</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Miller County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE <b>William Vanpool</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT Address <b>Mrs. Meredith Buck, Marshall, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> Interval BETWEEN ONSET AND DEATH <b>3 days</b> DUE TO (b) <b>Arterial Hypertension Grades</b> <b>10 yrs.</b> DUE TO (c) <b>Generalized Atherosclerosis</b> <b>25 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Coronary CVA - Arteriosclerotic Heart Disease</b> 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 <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 checked="" 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 <b>12 Apr 1958</b> to <b>12 Nov 1961</b> and last saw her alive on <b>12 Nov 1961</b> Death occurred at <b>4:31 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>L. M. Clarke, M.D.</b> (Doctor or title)				22b. ADDRESS <b>Marshall Mo</b>		22c. DATE SIGNED <b>13 Nov 61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/15/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) <b>Sedalia, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Walter Young</b> ADDRESS <b>Sedalia, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11-14-'61</b>		26. REGISTRAR'S SIGNATURE <b>Carl A. Reed</b>			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Quon Ewing

Licensed Embalmer No. 3847

P. O. Address Sedalia

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.