

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043376

STATE FILE NUMBER

AMENDED

Registration District No. 354 Primary Registration District No. 6200 Registrar's No. \_\_\_\_\_

**FILED DEC 4 1961**

1. PLACE OF DEATH a. COUNTY <u>TEXAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>TEXAS</u>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <u>MORRIS</u> Length of stay in 1b _____		c. CITY OR TOWN <u>MORRIS</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>RT. 4 MTN. GROVE</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RT. 4 MTN. GROVE</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE W VANDIVER</u>			4. DATE OF DEATH Month Day Year <u>NOV. 27-61</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>AUG. 27 1881</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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 <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>TEXAS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>WILEY J. Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Belle Padgett</u>		14. NAME OF HUSBAND OR WIFE <u>Marion</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Lizzie Coble Ben Davis, 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>Cerebrovascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) _____		

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	
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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 <u>DOA</u>	COUNTY _____ STATE _____
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21. I attended the deceased from 11/27/61 to 11/27/61 and last saw her/him alive on 11/27/61  
Death occurred at 10:10A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dand R. Crain</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Houston, Missouri</u>	22c. DATE SIGNED <u>11/28/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>NOV. 29-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROCK SPRINGS</u>	23d. LOCATION (City, town, or county) <u>TEXAS</u> (State) <u>MO</u>
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24. FUNERAL DIRECTOR <u>Barber</u> ADDRESS <u>7th St. Groe</u>	25. DATE RECD. BY LOCAL REG. <u>12/4/61</u>	26. REGISTRAR'S SIGNATURE <u>Hustardwick M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

DEC 8 1961

**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 RW Boothe

Licensed Embalmer No. 3848

P. O. Address Int'l. Str.

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.