

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-000018

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 47

AMENDED

FILED FEB 13 1962

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in lb <u>5 da.</u>	c. CITY OR TOWN <u>LaPlata</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>709 E. Patterson</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>ZELLA FAYE JAMES</u>			4. DATE OF DEATH Month Day Year <u>January 16, 1962</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-22</u>	9. AGE (last birthday) <u>39</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>9 2</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>Homemaking</u>		11. BIRTHPLACE (City and state or country) <u>Adair Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Forest Wolf</u>			13b. MOTHER'S MAIDEN NAME <u>Zovaletha Kephart</u>			14. NAME OF HUSBAND OR WIFE <u>Walter James</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>Walter James LaPlata, 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>Inanition - Massive Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Adenocarcinoma of Transverse Descending Colon</u>		
DUE TO (c) <u>Metastases to the Liver</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. <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>never</u> to _____ and last saw her/him alive on _____ Death occurred at <u>12:25 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Adair County Physician</u>	22b. ADDRESS <u>800 W. Jefferson, Kirksville, Mo.</u>	22c. DATE SIGNED <u>2/8/62</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-20-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	23d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Dee Riley Funeral Home, Inc., 415 North Franklin, Kirksville, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 8, 1962</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

FEB 19 1962

V. H. CASNER, D.D.

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 Kenneth C. Hayes

Licensed Embalmer No. 4890

P. O. Address Fairbault, 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.