

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001172

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 173

AMENDED FILED FEB 13 1962

1. PLACE OF DEATH a. COUNTY <u>Green</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b	c. CITY OR TOWN <u>Mtn. View (Rural)</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>St. John Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Calloway Humphrey</u>			4. DATE OF DEATH Month Day Year <u>January 28, 1962</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>F.</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>9/3/1904</u>	9. AGE (last birthday) <u>57</u>	
IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>shoe repair man</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mtn. View, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Lewis Humphrey</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Boy</u>		14. NAME OF HUSBAND OR WIFE <u>Rena C. Humphrey</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>No</u>	17. INFORMANT <u>Rena Humphrey Mtn. View, Mo. Rt 2</u> 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) <u>Respiratory Paralysis</u> DUE TO (b) <u>Myelitis</u> DUE TO (c) <u>Severe Oral sepsis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
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 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>December 29, 1961</u> and last saw her <u>January 28, 1962</u> and last saw him alive on <u>January 28, 1962</u> Death occurred at <u>4-35 P. M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>H. Terrell</u> (Degree or title)			22b. ADDRESS <u>Springfield Mo.</u>		22c. DATE SIGNED <u>2-2-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/31/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cem.</u>	23d. LOCATION (City, town, or county) <u>Mtn. View, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn. View, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-5-62</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 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

Brie M. Abbott

Licensed Embalmer No.

5115

P. O. Address

Jerryfield

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.