

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-002753

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 5779 Primary Registration District No. 9 Registrar's No. 9

FILED FEB 13 1962

1. PLACE OF DEATH a. COUNTY <u>MILLER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>MILLER</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>AURORA-SPRINGS</u>		Length of stay in lb <u>3 yrs</u>		c. CITY OR TOWN <u>ELDON</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>AURORA-SPRINGS</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>AURORA-SPRINGS</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA- ELIZABETH MAY</u>				4. DATE OF DEATH Month Day Year <u>JAN- 24 1962</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>4 Nov-1874</u>	
9. AGE (last birthday) <u>87</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House- Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At-Home</u>		11. BIRTHPLACE (City and state or country) <u>Jasper-Co-Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Wiley-Routon</u>			13b. MOTHER'S MAIDEN NAME <u>SARAH-PITMAN</u>			14. NAME OF HUSBAND OR WIFE <u>RICHARD-MAY</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 <u>CLAY-MAY</u> Address <u>ELDON-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>Congestive heart failure</u> DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</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 checked="" 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.) <u>NONE</u>			
20c. TIME OF INJURY Hour a.m. p.m. <u>NONE</u>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		20f. CITY, TOWN, OR LOCATION <u>NONE</u>		COUNTY STATE	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from <u>Dec 1961</u> to <u>1/24/62</u> and last saw her <u>alive</u> on <u>1/31/62</u> Death occurred at <u>5:50 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robt. Edmunds D.O.</u>				22b. ADDRESS <u>ELDON MO</u>		22c. DATE SIGNED <u>26 JAN-62</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>27 JAN-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>South-Side</u>		23d. LOCATION (City, town, or county) <u>Meta MO</u>	
24. FUNERAL DIRECTOR <u>Keith McKays</u> ADDRESS <u>ELDON-MO</u>				25. DATE RECD. BY LOCAL REG. <u>Jan. 26, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Alvaretta Dally</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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 Keith M. Kays

Licensed Embalmer No. 3998

P. O. Address Eldon 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.