

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003364

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 53

FILED FEB 6 1962

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Twp. Farmington-rural		c. CITY OR TOWN Farmington	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mineral Area Hospital		d. STREET ADDRESS (If outside, give location) RFD # 1	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Clarence Middle E. Last Mongerson	4. DATE OF DEATH Month January Day 31 Year 1962
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1889	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired mail carrier	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Eldon, Iowa	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Swin Mongerson	13b. MOTHER'S MAIDEN NAME Elsie Fairchild	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.I.	16. SOCIAL SECURITY NO.	17. INFORMANT Clyde Shris Mongerson, Farmington, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 days Unknown
IMMEDIATE CAUSE (a) Hypostatic Pneumonia		
DUE TO (b) Acute brain syndrome associated with convulsive disorder		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (c) Due to arteriosclerosis and cerebral anoxia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of surgical neck Right femur (Open reduction with pinning)	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 _____
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21. I attended the deceased from Jan. 24 - 1962 to Jan. 31 - 1962 and last saw him alive on Jan. 31 - 1962.
Death occurred at 8:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS Farmington, Mo	22c. DATE SIGNED 2/1/62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/3/62	23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery	23d. LOCATION (City, town, or county) (State) Farmington, Missouri
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24. FUNERAL DIRECTOR Miller Funeral Home Farmington, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. Feb 2, 1962	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

FEB 15 1962

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 Paul K. Deval

Licensed Embalmer No. 4020

P. O. Address Farmington N

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.