

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006936

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 34

FILED FEB 20 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jasper	e. STATE Missouri COUNTY Jasper		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webb City	Length of stay in 1b 2 days	c. CITY OR TOWN Carterville	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jane Chinn Hospital	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 401 West Main St.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Fred Middle Last Trapp	4. DATE OF DEATH	Month February Day 15 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 9-2-1878	9. AGE (last birthday) 83	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) Plumbing	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT Thelma Keck 401 W. Main St. Carterville, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Hypostatic Lobar Pneumonia (Pathological)	2 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) Fracture of upper third of left femur	3 Days
DUE TO (c) Metastasis from Carcinoma of Prostate	State Cannot

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Large incisional hernia - loss of vision both eyes	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.)
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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 **2-13-62** to **2-15-62** and last saw her/him alive on **2-15-62**
Death occurred at **11:50A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm. Webb Beck D.O.	22b. ADDRESS Webb City, Missouri	22c. DATE SIGNED 2-15-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-19-62	23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery	23d. LOCATION (City, town, or county) (State) Liberty, Missouri
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24. FUNERAL DIRECTOR Johnston-Simpson, Webb City, Mo.	25. DATE RECD. BY LOCAL REG. 2-16-62	26. REGISTRAR'S SIGNATURE Mrs. Madeline Switzer
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 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 Clayton M Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City, 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.