

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007152

STATE FILE NUMBER

AMENDED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 29

FILED FEB 21 1962

1. PLACE OF DEATH a. COUNTY <u>Macon</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>Macon</u>		Length of stay in 1b <u>1/1</u>	c. CITY OR TOWN <u>Macon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>503 Malone</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>503 Malone</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Pauline</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1962</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1917</u>	9. AGE (last birthday) <u>44</u>	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) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Ethel, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Nellie Bodenhamer</u>	14. NAME OF HUSBAND OR WIFE <u>no.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <u>No</u>   <u>no</u>	16. SOCIAL SECURITY NO. <u>no.</u>	17. INFORMANT <u>Mrs. Nellie Wright</u>	Address <u>Macon, Mo.</u>
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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
IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>		<u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Metastases of the lung and brain (primary)</u>	
	<u>Obstruction site left mammary gland</u>	<u>unknown</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.)
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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 1940 to \_\_\_\_\_ and last saw her/him alive on Feb 13, 1962  
Death occurred at 7:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Hubert S. Sutton, M.D.</u>	22b. ADDRESS <u>Macon, Missouri</u>	22c. DATE SIGNED <u>2-15-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 15, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bell Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Macon County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Lister Sutton</u>	ADDRESS <u>Macon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2/16/62</u>	26. REGISTRAR'S SIGNATURE <u>Kath McNeely</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 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 Charles L. Hutton

Licensed Embalmer No. 4577

P. O. Address Macon, 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.