

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007367
STATE FILE NUMBER

AMENDED

Registration District No. 264 Primary Registration District No. 5892 Registrar's No. 6

FILED FEB 26 1962

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Ozark</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tecumseh</u>		Length of stay in 1b <u>mos.</u>	c. CITY OR TOWN <u>Tecumseh</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>R. J. D.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. J. D.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily Francis Price</u>			4. DATE OF DEATH Month Day Year <u>Feb. 6, 1962</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>wht.</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>7-9-1866</u>	9. AGE (last birthday) <u>84 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Taylor Co., Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Oakes</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Oakes</u>	
14. NAME OF HUSBAND OR WIFE <u>dec.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>no.</u>	
17. INFORMANT <u>Oda Warren, Tecumseh, Mo.</u>		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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis</u>	
	DUE TO (c)	

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 11:30 p.m. 1960 to 2-6-62 and last saw her alive on 2-1-62
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. Callahan M.D.</u> (Degree or title)	22b. ADDRESS <u>West Plains, Mo</u>	22c. DATE SIGNED <u>2-12-62</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>2-8-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lilly Ridge Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Gainesville, Ozark, Mo.</u>
---	------------------------------	---	---

24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-17-62</u>	26. REGISTRAR'S SIGNATURE <u>Lou Anna Wade</u>
---	---------	--	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 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  _____

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.