

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009530

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 324

Primary Registration District No. 3012

Registrar's No. 45

FILED MAR 5 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>4 days</b>	c. CITY OR TOWN <b>Slater</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>309 E. Emma</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Dovie</b> Middle <b>Ann</b> Last <b>Kammeyer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/1890</b>
9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Arrow Rock, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Don Boggs</b>	
13b. MOTHER'S MAIDEN NAME <b>Nellie Hoke</b>		14. NAME OF HUSBAND OR WIFE <b>Walter Kammeyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <b>Mrs. Frank Sinnett, Slater, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vas Accident</b> <b>Cerebral Vas Thrombosis</b> <b>Cerebral Vas Sclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arterio Sclerosis</b>			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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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 <b>Arrow Rock</b> COUNTY _____ STATE _____	
21. I attended the deceased from <b>Feb 26</b> to <b>Mar 2</b> and last saw him alive on <b>Mar 2</b> Death occurred at _____ 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 <b>Marshall Mo</b>	
22c. DATE SIGNED <b>2-2-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/4/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arrow Rock</b>	23d. LOCATION (City, town, or county) (State) <b>Arrow Rock, Missouri</b>
24. FUNERAL DIRECTOR <b>Haines Funeral Home, Slater, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-3-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

**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 Walter J. Haines, Jr.

Licensed Embalmer No. 4557

P. O. Address Slater, 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.