

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED MAR 19 1962 38

62-009883
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 7157

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0109
2 0340

3

4 1

5 0

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9 2001

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11

12 2-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Douglas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Length of stay in lb 24 DAYS	c. CITY OR TOWN DRURY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION University of Missouri Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) DRURY
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN Sue HOMAN			4. DATE OF DEATH Month Day Year MARCH 13 1962		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1943	9. AGE (last birthday) 18	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY DRURY, MO.	11. BIRTHPLACE (City and state or country) U.S.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Bud Homan		13b. MOTHER'S MAIDEN NAME Dorothy Cobb		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	17. INFORMANT Address Medical Record U.M.M.C. Hosp't		

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) SHOCK		3 HOURS
DUE TO (b) ANEMIA		6 MONTHS
DUE TO (c) LYMPHOSARCOMA		19 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) OBSTRUCTIVE UROPATHY		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 checked="" 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 **Feb. 17, 1962** to **MAR. 13, 1962** and last saw her alive on **MAR. 13, 1962**
Death occurred **ON MARCH 13, 1962, 6:10 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert W. Moellenhoff M.D.	22b. ADDRESS Univ. of Mo. Med. Center Columbia, MO.	22c. DATE SIGNED MAR. 13 '62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-14-62	23c. NAME OF CEMETERY OR CREMATORY Pleasant Home
24. FUNERAL DIRECTOR Barber Funeral Home Mt. Hope, Mo.	25. DATE RECD. BY LOCAL REG. Mar 14 1962	26. REGISTRAR'S SIGNATURE Miss RE Palmer

USE BLACK INK OR TYPEWRITER RIBBON

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. _____

P. O. Address _____

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.