

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009931

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 359

STATE FILE NUMBER

FILED APR 2 1962

VS 300 Rev. 4/59

1 5117

2 5717

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

M.F. Grimes, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, | | c. CITY OR TOWN St. Joseph, | |
| Length of stay in 1b 44yrs | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital | | d. STREET ADDRESS 622 Dewey | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Lottie Leona Chastain | | 4. DATE OF DEATH Month Day Year Mar. 25, 1962 | |
| 5. SEX Female | 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 Jan. 26, 1883 |
| 9. AGE (last birthday) 79 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Forrest City Mo |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Cammandore DeVault | |
| 13b. MOTHER'S MAIDEN NAME Emma Jane Frazier | | 14. NAME OF HUSBAND OR WIFE None | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. Dorothy Worthen, St. Joseph, Mo | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. & Rt hemiplegia DUE TO (b) Gen arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 2 days yes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) gangrene - Both lower extremities | | | 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.) | | | |
| 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 Mar 22 nd to 3/25/62 and last saw her alive on 3-24-62 | | Death occurred at 6:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE M.F. Grimes (Degree or title) | | 22b. ADDRESS St Joseph Mo | |
| 22c. DATE SIGNED 3-26-62 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3/27/62 | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | 23d. LOCATION (City, town, or county) St. Joseph, Mo |
| 24. FUNERAL DIRECTOR St. Joseph, Mo | | 25. DATE RECD. BY LOCAL REG. Mar. 27, 1962 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Stadell |

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 John E. Papp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.