

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-010045

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 640

FILED MAR 19 1962

VS 300
Rev. 4/59

1 0128

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BUTLER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DUNKLIN									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF			Length of stay in 1b 11 days		c. CITY OR TOWN CAMPBELL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 324 MONROE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Henry Last BYERS				4. DATE OF DEATH Month 3 Day 3 Year 1962									
5. SEX MALE		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 7-10-88		9. AGE (last birthday) 73		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (City and state or country) BEDFORD, INDIANA		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME J. H. BYERS				13b. MOTHER'S MAIDEN NAME KATHRYN GAINS				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) YES WORLD WAR I				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.							
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) Acute myocardial infarction										15 days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										-			
DUE TO (b) Arteriosclerotic heart disease										-			
DUE TO (c) Generalized and cerebral arteriosclerosis										-			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal pneumonitis.								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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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		COUNTY		STATE					
21. I attended the deceased from February 20, 1962 to March 3, 1962 and last saw him on March 3, 1962 . Death occurred at 12:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Robert S. Cohen ROBERT S. COHEN, M.D., CHIEF, MED. SERVICE						22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.			22c. DATE SIGNED 3-7-62				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 5, 1962		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) Campbell, Missouri							
24. FUNERAL DIRECTOR Landess Funeral Home, Campbell, Mo.				25. DATE RECD. BY LOCAL REG. 3/16/1962		26. REGISTRAR'S SIGNATURE Thelma Graham							

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 Christine Lander Beall

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.