

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-010273

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 29 Primary Registration District No. 3015 Registrar's No. 28

FILED MAR 22 1962

VS 300
Rev. 4/59

1 0.251

2 0.320

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4 1

5 1

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7 0

8 0

9 1532

10

11

12 1-2

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY DeKalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cameron		Length of stay in 1b 7 Weeks	c. CITY OR TOWN Maysville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cameron Community Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CASSIE Middle VIOLA Last MARSHALL			4. DATE OF DEATH Month Mar. Day 10 Year 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/1-1882
9. AGE (last birthday) 79		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) DeKalb County Mo
12. CITIZEN OF WHAT COUNTRY U.S.		13. NAME OF HUSBAND OR WIFE William S. Marshall	
13a. FATHER'S NAME Tom Humphrey		13b. MOTHER'S MAIDEN NAME Lucy Ann Collier	
14. NAME OF DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		15. SOCIAL SECURITY NO.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address William S. Marshall Maysville Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Descending Colon 2 1/2 in?</i> DUE TO (b) <i>and Colored Polycystic</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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)			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 <u>Mar 19 1962</u> to <u>Mar 10 1962</u> and last saw her alive on <u>Mar 9 1962</u> Death occurred at <u>6:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Donald Fowler M.D.</i>		22b. ADDRESS Maysville Missouri	
22c. DATE SIGNED 3/12/62		22d. LOCATION (City, town, or county) Maysville Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/10-62	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION (City, town, or county) Maysville Missouri	
24. FUNERAL DIRECTOR Pilcher Funeral Home Maysville Mo.		25. DATE RECD. BY LOCAL REG. March 13 1962	
26. REGISTRAR'S SIGNATURE <i>Francis D. Crawford</i>			

USE BLACK INK OR TYPEWRITER RIBBON

MAY 2 1963

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 
C.T. Plicher

Licensed Embalmer No. 3960

P. O. Address Maysville Missouri

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.