

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-010697

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 42

DO NOT WRITE ON THIS STUB

AMENDED **F**

FILED MAR 19 1962

VS 300
Rev. 4/59

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20465

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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 <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains,</u>		Length of stay in 1b <u>since 1958</u>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Heinrich Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Heinrich Rest Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Alfred</u> Last <u>McDonald</u>			4. DATE OF DEATH Month <u>March</u> Day <u>6,</u> Year <u>1962</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>wht.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-1870</u>
9. AGE (last birthday) <u>91</u>		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) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	11. BIRTHPLACE (City and state or country) <u>West Plains, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Joe McDonald</u>	
13b. MOTHER'S MAIDEN NAME <u>Tilda Holman</u>		14. NAME OF HUSBAND OR WIFE <u>--</u>	
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. <u>no</u>	17. INFORMANT <u>Pearl Proctor, Kansas City, Mo.</u> 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) <u>Prob myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ASITD</u>			?
DUE TO (c) <u>GAS</u>			?
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 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 <u>12-16-61</u> to <u>3-5-62</u> and last saw ^{her} him alive on <u>3-5-62</u> Death occurred at <u>6:00</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John E. Wilson, M.D.</u>		22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>3-11-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>3-9-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Free Union Cemetery</u>	23d. LOCATION (City, town, or county) <u>Leota, Howell, Mo.</u>
24. FUNERAL DIRECTOR <u>Robertson's, West Plains, Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>3-14-62</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

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. 3432

P. O. Address West Plains, 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.