

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012265

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

FILED MAR 19 1962

Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

VS 300  
Rev. 4/59

1 0870  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Ralls</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Ralls</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>New London</b> Length of stay in 1b		c. CITY OR TOWN <b>New London</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>New London</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY REBECCA FLOWERREE RILEY</b>			4. DATE OF DEATH Month Day Year <b>March 13, 1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>77</b> IF UNDER 1 YEAR Months Day Hours Min. <b>21</b>
11. BIRTHPLACE (City and state or country) <b>Center Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>George F. Flowerree</b>		13b. MOTHER'S MAIDEN NAME <b>Mary K. Rice</b>	14. NAME OF HUSBAND OR WIFE <b>J. A. Riley</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>J. R. Flowerree Center Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senile Anemia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hodgkins Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>9 mo</b>
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>3:20 P.</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R M Anthony MD</b>		22b. ADDRESS <b>Hannibal, Mo.</b>	22c. DATE SIGNED <b>3/16/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 15, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Center Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Smith's Funeral Home Hannibal Missouri</b>		25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE <b>Clyde E. Wilkey</b>	

**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 S. St Paul*

Licensed Embalmer No. 4540

P. O. Address Hannibal 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.