

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013888

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 52

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 3 1962

VS 300  
Rev. 4/59

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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 <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Barry Co.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Washington Township</b>		Length of stay in 1b <b>30yrs.</b>	c. CITY OR TOWN <b>Cassville, Mo.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #3</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>None</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mabel Kring</b>			4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>1962</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/1897</b>
9. AGE (last birthday) <b>65yrs</b>		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) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Cassville, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>G. W. Kring</b>	
13b. MOTHER'S MAIDEN NAME <b>Mollie Woody</b>		14. NAME OF HUSBAND OR WIFE <b>Single</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. <b>None</b>	
17. INFORMANT <b>Hospital Records, Nevada, Mo.</b>		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) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3hrs.</b>
DUE TO (b) <b>Obesity</b>			
DUE TO (c) _____			
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 viewed the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>1:10</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. I viewed the remains:			
22a. SIGNATURE <i>F.S. Martin</i>		22b. ADDRESS <b>5 + HOSP # 3</b>	22c. DATE SIGNED <b>3/26/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-28-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>CASSVILLE, MISSOURI</b>
24. FUNERAL DIRECTOR <b>WILLIAMSON FUNERAL HOME, CASSVILLE, MO. 3-31-62</b>		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <i>Anna B. Perry</i>

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 L. Augustus Fung

Licensed Embalmer No. 4960

P. O. Address Neenah, Wisconsin

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.