

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-014028
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 27 Primary Registration District No. 4031 Registrar's No. 86

FILED MAY 1 1962

VS 300
Rev. 4/59
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20070
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Bates		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Bates	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Adrian		Length of stay in lb 5 years	c. CITY OR TOWN Adrian
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		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 Middle Last Tessie Lee Haggard			4. DATE OF DEATH Month Day Year April 21 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 11-26-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 78 IF UNDER 1 YEAR Months 4 Days 25 IF UNDER 24 HR Hours 25 Min.
11a. BIRTHPLACE (City and state or country) Cass County, Mo.		11. BIRTHPLACE (City and state or country) U.S.A.	
13a. FATHER'S NAME John W. Cox		13b. MOTHER'S MAIDEN NAME Nancy Jane Reeder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [Redacted]	
17. INFORMANT Glen Henry Haggard, Adrian, Mo.		14. NAME OF HUSBAND OR WIFE Glen Henry Haggard	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Cardiac Decompensation DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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			INTERVAL BETWEEN ONSET AND DEATH 7 hrs 1 hr
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 Feb 17 1961 to April 21 1962 and last saw her ^{him} alive on April 21 1962 I certify that the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at 7:20 P.M.			
22a. SIGNATURE (Degree or title) Dr. Colson DO		22b. ADDRESS Adrian Mo	22c. DATE SIGNED 4/23/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-24-62	23c. NAME OF CEMETERY OR CREMATORY Crescent Hill Cemetery	23d. LOCATION (City, town, or county) (State) Adrian, Mo.
24. FUNERAL DIRECTOR Six Funeral Service, Adrian, Mo.		25. DATE RECD. BY LOCAL REG. 4-24-62	26. REGISTRAR'S SIGNATURE Norma Jean Wilson

USE BLACK INK OR TYPEWRITER RIBBON

MAY 9 1962

OCT 4 1962

MAY 2 1962

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. 3650

P. O. Address Adrian, 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.