

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-014299

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 695

FILED APR 16 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DUNKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 1 DAY	c. CITY OR TOWN CLARKTON Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NONE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BEE Middle (NONE) Last BOONE			4. DATE OF DEATH Month MARCH Day 24 , Year 1962
5. SEX MALE	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 10-30-96
9. AGE (last birthday) 65		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) PAPER HANGER		10b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE	11. BIRTHPLACE (City and state or country) GIBSON, MISSOURI
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME BUNK BOONE 13b. MOTHER'S MAIDEN NAME MINNIE HOGGARD 14. NAME OF HUSBAND OR WIFE TELIE BOONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, 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) CEREBRAL HEMORRHAGE. DUE TO (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE. DUE TO (c) ARTERIO-NEPHROSCLEROSIS. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 Hours 6 Years -----
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.) VA		20f. CITY, TOWN, OR LOCATION VA	
20g. COUNTY		20h. STATE	
21. I attended the deceased from March 24, 1962 to March 24, 1962 and last saw him her alive on March 24, 1962 Death occurred at 12:55 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Cohen (Degree or title) ROBERT S. COHEN, M.D., Chief, Medical Svc. VA Hospital, Poplar Bluff, Mo.		22b. ADDRESS VA Hospital, Poplar Bluff, Mo.	22c. DATE SIGNED 3/27/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/26/1962	23c. NAME OF CEMETERY OR CREMATORY Stanfield	23d. LOCATION (City, town, or county) (State) Near Clarkton, Missouri
24. FUNERAL DIRECTOR McDaniel Funeral Ser. Kennett, Mo.		25. DATE RECD. BY LOCAL REG. 4/14/1962	26. REGISTRAR'S SIGNATURE Helma Seaman.

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 Charles E. Mungler

Licensed Embalmer No. 4877

P. O. Address Poplar Bluff, 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.