

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-015935

STATE FILE NUMBER

Registration District No. 981 Primary Registration District No. 9089 Registrar's No. 71

FILED APR 17 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0581

2 0581

3 2

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12 4-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		c. CITY OR TOWN <u>MARCELINE</u>	
Length of stay in 1b		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>ST. FRANCIS HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>W. Howell</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLACE CLEO SEARCY</u>			4. DATE OF DEATH Month Day Year <u>4 - 11 - 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1885</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>25</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT&TF Rwy.</u>	11. BIRTHPLACE (City and state or country) <u>KNOX Co. MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>EDWARD SEARCY</u>	
13b. MOTHER'S MAIDEN NAME <u>ANNA BOVE</u>		14. NAME OF HUSBAND OR WIFE <u>DELL SEARCY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>ALLEN SEARCY</u>
Address <u>OMAHA NEBR.</u>		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>Relapsing Erythema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>	
DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>years</u>	
DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>4 Pneumonia w/ dehydration 3) cerebral thrombosis 4) malnutrition 5) cardiac decompensation</u>	
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 <u>1957</u> to <u>4-11-62</u> and last saw him alive on <u>4-11-62</u>		Death occurred at <u>11 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Marceline, Missouri</u>	
22c. DATE SIGNED <u>4-12-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>4-12-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WYACONDA CEM.</u>	
23d. LOCATION (City, town, or county) (State) <u>WYACONDA MO.</u>		24. FUNERAL DIRECTOR <u>Miller-Tillotson</u>	
ADDRESS <u>MARCELINE MO.</u>		25. DATE RECD. BY LOCAL REG. <u>4-12-62</u>	
26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>			

USE BLACK INK OR TYPEWRITER RIBBON

APR 18 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 Silburn K. Tiltonson

Licensed Embalmer No. 4508

P. O. Address Marble Hill, 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.