

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016131
STATE FILE NUMBER

Registration District No. 240 Primary Registration District No. 4358 Registrar's No. 12

FILED MAY 8 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0720
2 0720
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4 1
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9 331X
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12 90-2
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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 New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lilbourn		Length of stay in 1b 40 years	c. CITY OR TOWN Lilbourn Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 323 Warring St		d. STREET ADDRESS (If outside, give location) 323 Warring St	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Christine L. Ross			4. DATE OF DEATH Month Day Year April 27 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-30-1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 76 IF UNDER 1 YEAR IF UNDER 24 HR Months 2 Days 24 Hours Min.
11. BIRTHPLACE (City and state or country) Evansville, Indiana		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME A. W. Wallace		13b. MOTHER'S MAIDEN NAME Rosan Brown	14. NAME OF HUSBAND OR WIFE
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. None	17. INFORMANT Address Ada McIntosh-Lilbourn, 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) Pneumonia - Lobar Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Malaria DUE TO (c) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 3 days. 3 weeks 3 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 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 4-27-62 to 4-27-62 and last saw her/him alive on 4-27-62 Death occurred at 8:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James O. Cameron M.D.		22b. ADDRESS Lilbourn Mo	22c. DATE SIGNED 4-30-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-30-62	23c. NAME OF CEMETERY OR CREMATORY Mounds Park	23d. LOCATION (City, town, or county) (State) Near Lilbourn, Mo.
24. FUNERAL DIRECTOR ADDRESS Ponder Funeral Home-Lilbourn, Mo.		25. DATE RECD. BY LOCAL REG. 4-30-1962	26. REGISTRAR'S SIGNATURE Charles Simpson ss H. L. Ponder

Dr. Liberman

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,

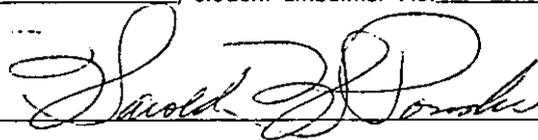
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 5030

P. O. Address Liberman, Dr.

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.