

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-016197

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 257

Primary Registration District No. 4389

Registrar's No. 22

FILED APR 26 1962

VS 300
Rev. 4/59

1 0760

2 0760

3 2

4 0

5 1

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7 0

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9 738X

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11

12 90-0

13 2-0

DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Osage</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Linn</u>		Length of stay in lb <u>Life</u>	c. CITY OR TOWN <u>Linn</u> 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>at his home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>Linn Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Buell Franklin Ferrier</u>		4. DATE OF DEATH Month Day Year <u>April 22 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>8/20/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Field Representative, retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Clay mining</u>	11. BIRTHPLACE (City and state or country) <u>Linn Mo</u>
13a. FATHER'S NAME <u>James A Ferrier</u>		13b. MOTHER'S MAIDEN NAME <u>Dora B Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv <u>no</u>		17. INFORMANT <u>Mrs Buell Ferrier</u> Linn Mo	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Pericarditis nodosa</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
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 attended the deceased from <u>3-7-62</u> to <u>4-21-62</u> and last saw her alive on <u>4-21-62</u> Death occurred at <u>6:30am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. V. M. Kelly M.D.</u>		22b. ADDRESS <u>507 East High St Jefferson Mo</u>	
22c. DATE SIGNED <u>4-20-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>4/25/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Linn Memorial Park</u>		23d. LOCATION (City, town, or county) <u>Linn Mo</u>	
24. FUNERAL DIRECTOR <u>Clyde Morton</u>		25. DATE RECD. BY LOCAL REG. <u>April 25, 1962</u>	
ADDRESS <u>Linn Mo</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clyde Morton</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

MAY 11 1962

APR 26 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 Theron M. Maston

Licensed Embalmer No. 4125

P. O. Address Lynn, Ma

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.