

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-017917

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 114

FILED MAY 21 1962

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Rev. 4/59

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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>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b	c. CITY OR TOWN <u>Wellsville</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>1020 S. Muldrow</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>406 E. Bates</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Linnie Foreman VanLeer</u>			4. DATE OF DEATH Month Day Year <u>May 5, 1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1879</u>
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Montgomery Co, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Oscar Hampton</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary E. Green</u>		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) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Rachel Williamson, Mexico</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>Mitotic disease generalized</u> DUE TO (b) <u>Carcinoma Esoph</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>2 years</u>
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 checked="" 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 Month, Day, Year a.m. p.m.		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>Nov. 1952</u> to <u>May 5-62</u> and last saw her alive on <u>May 5-62</u> Death occurred at <u>10p m on the date stated above, and to the best of my knowledge, from the causes stated.</u>			
22a. SIGNATURE (Degree or title) <u>Harold S. Sanford M.D.</u>		22b. ADDRESS <u>Mexico Mo</u>	22c. DATE SIGNED <u>5-12-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>May 7, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montgomery City, Mo</u>	23d. LOCATION (City, town, or county) (State) <u>Montgomery City, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Howard F. Myers, Wellsville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 14-1962</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>

USE BLACK INK

TYPEWRITER RIBBON  
Harold S. Sanford (M.D.)

Permit obtained  
5-15-62  
137

**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 \_\_\_\_\_

*Howard Myers*

Licensed Embalmer No. 4494

P. O. Address ~~xxxxxx~~ Wellsville, 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.