

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018109

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042

Primary Registration District No. _____

Registrar's No. 593

STATE FILE NUMBER

FILED JUN 4 1962

VS 300
Rev. 4/59

15110

25110

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1290-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

M.H. Christ, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | |
|--|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN DeKalb, | | Length of stay in 1b 78yrs | | c. CITY OR TOWN DeKalb, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DeKalb, | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) XX Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bessie Jane McClurg | | | 4. DATE OF DEATH Month Day Year May 21, 1962 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 23, 1883 | 9. AGE (last birthday) 78 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house keeper | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Buchanan Co, Mo | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Lafe McClurg | | 13b. MOTHER'S MAIDEN NAME Sarah Hickamn | |
| 14. NAME OF HUSBAND OR WIFE none | | 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 Fannie Dittimore, DeKalb, 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) <i>Arteriosclerotic Heart Disease with Congestive Heart Failure</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Congestive Heart Failure</i> DUE TO (c) | | | | | |
| 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 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>1959</u> to <u>5/21/62</u> and last saw her <u>alive</u> on <u>May 17, 1962</u> Death occurred at <u>5A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>Martin H. Christ</i> (Degree or title) | | | 22b. ADDRESS <i>6106 King Hill Ave</i> | | 22c. DATE SIGNED <i>5/21/62</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>5/23/62</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Westlawn Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>DeKalb, Mo</i> | |
| 24. FUNERAL DIRECTOR <i>Joseph</i> ADDRESS <i>St. Joseph, Mo</i> | | 25. DATE RECD. BY LOCAL REG. <i>May 28, 1962</i> | | 26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i> | |

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

John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.