

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019483

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 178 Primary Registration District No. \_\_\_\_\_ Registrar's No. 44

FILED MAY 22 1962

VS 300  
Rev. 4/59

1 0560

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>LEWIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>LEWIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MONTICELLO</b>		Length of stay in 1b <b>XXXXXXXXXX</b>	c. CITY OR TOWN <b>MONTICELLO</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>XXXXXXXXXXXXXXXXXXXXXX</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OWEN</b> Middle <b>GABRIEL</b> Last <b>JENKINS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/23/80</b>
9. AGE (last birthday) <b>82yrs.</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>XXXXXXXXXXXXXXXXXX</b>	11. BIRTHPLACE (City and state or country) <b>LEWIS COUNTY</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>JOHN C. JENKINS</b>	
13b. MOTHER'S MAIDEN NAME <b>MARY PEARL</b>		14. NAME OF HUSBAND OR WIFE <b>MARGARET</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>XXXXXXXXXXXX</b>	17. INFORMANT Address <b>MO. MRS. WALLACE VEATCH, MONTICELLO,</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Insufficiency</b> DUE TO (b) _____ 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 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 <b>May 7 1962</b> to <b>May 14 1962</b> and last saw him alive on <b>May 13 1962</b> Death occurred at <b>5:30 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dr. C. E. Todd</b>		22b. ADDRESS <b>Williamstown Mo</b>	22c. DATE SIGNED <b>5/17/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5/16/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MONTICELLO</b>	23d. LOCATION (City, town, or county) (State) <b>MONTICELLO, MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>Charles L. Arnold, Jr. LEWISTOWN, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>5-18-62</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Henry Lloyd</b>

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 Charles L. Arnold, Jr.

Licensed Embalmer No. 4667

P. O. Address LEWISTOWN, MISSOURI

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.