

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019532

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 5890 Registrar's No. 116

FILED JUN 11 1962

VS 300  
Rev. 4/59  
0590  
2590  
3  
4 1  
5 2  
6  
7 1  
8 2  
9331X  
10  
11  
1290-2  
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LIVINGSTON</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cream Ridge Twp</u>		Length of stay in 1b <u>15-MONTHS</u>	c. CITY OR TOWN <u>Chula</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Em West Chula</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Chula</u>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Case</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>Female</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>8/12/1876</u>
9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u>	IF UNDER 24 HR Hours <u>20</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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Cottonwood Falls KS</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>George Doney</u>	
13b. MOTHER'S MAIDEN NAME <u>Emma Knott</u>		14. NAME OF HUSBAND OR WIFE <u>J. W. Case</u>	
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. Wallace Hooker - Chula - Mo</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>Cerebral Hemorrhage</u> DUE TO (b) <u>arterial Sclerosis</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>2 years</u> <u>and 4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cachexia + Inanition</u>			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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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. 1960</u> to <u>6-2-62</u> and last saw her <u>alive</u> on <u>5-15-62</u> Death occurred at <u>8:20 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J.B. Webber D.O.</u>		22b. ADDRESS <u>901 Jackson Chillicothe Mo</u>	22c. DATE SIGNED <u>6-2-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/4/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>May Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chula Mo</u>
24. FUNERAL DIRECTOR <u>E.J. Robertson Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>June 2, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Annalise Taylor</u>

**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 J. M. Robertson

Licensed Embalmer No. 4388

P. O. Address Laredo, TX

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.