

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020065

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 314

Primary Registration District No. 4459

Registrar's No. 93

FILED JUN 6 1962

VS 300 Rev. 4/59					
1 <u>09.30</u>	DATE AMENDED				
2 <u>09.30</u>					
3					
4 <u>1</u>					
5 <u>2</u>					
6					
7 <u>1</u>					
8 <u>0</u>					
9 <u>332X</u>					
10					
11					
12 <u>2-0</u>					
13 <u>2-0</u>					

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 St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Osceola		c. CITY OR TOWN Osceola Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Osceola Med. Hosp.		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Ona Middle Henry Last Henry		4. DATE OF DEATH Month May Day 21 Year 1962	
5. SEX Fe	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1966
9. AGE (last birthday) 95		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HR. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Illinois	11. BIRTHPLACE (City and state or country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME William Staley	
13b. MOTHER'S MAIDEN NAME Eliza Anderson		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) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Kate Durnell		Address Osceola 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) Cerebral thromboses			INTERVAL BETWEEN ONSET AND DEATH 3da
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) acute cholecystitis			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 1 July 61 to 21 May 62 and last saw her alive on 21 May 62 . Death occurred at 4 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J.H. Lester MD (Degree or title)		22b. ADDRESS Osceola Mo.	
22c. DATE SIGNED 5-29-			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-23-62	23c. NAME OF CEMETERY OR CREMATORY Osceola Cem.	23d. LOCATION (City, town, or county) (State) Osceola Mo.
24. FUNERAL DIRECTOR Goodrich Funeral Home ADDRESS Osceola Mo.		25. DATE RECD. BY LOCAL REG. 5-29-62	
26. REGISTRAR'S SIGNATURE Ruth Seavers			

4 PM

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 Paul Dickson

Licensed Embalmer No. 3990

P. O. Address Orleans, Me.

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.