

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020114

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 224

FILED MAY 29 1962

VS 300
Rev. 4/59

10940

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST FRANCOIS</u>		a. STATE <u>MO</u> b. COUNTY <u>ST FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BONNE TERRE, MO.</u>		c. CITY OR TOWN <u>ELVINS</u>	
Length of stay in 1b		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>BONNE TERRE, HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>ELVINS, MO.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>JAMES ANDERSON TEAGUE</u>		Month Day Year <u>5 25 62</u>	
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<u>MALE</u>	<u>WHITE</u>		<u>10/15/1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (City and state or country) <u>MARTIN WEEKLEY CO. TENN. U.S.A.</u>
13a. FATHER'S NAME <u>WILLIAM H. TEAGUE</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH E. BRAY</u>	14. NAME OF HUSBAND OR WIFE <u>ADA TEAGUE</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>PATRAH MEADOR, ELVINS, MO</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Laceration Throat self-inflicted</u>			<u>2 days</u>
DUE TO (b) <u>Broncho pneumonia</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus.</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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Cut throat with knife</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>6 p.m. May 22 62</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>317 W. MAIN ELVINS ST. FRANCOIS MO</u>	
21. I attended the deceased from <u>May 22 62</u> to <u>May 25 62</u> and last saw ^{him} live on <u>May 25</u> Death occurred at <u>11:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>C. H. Appleberry MD</u>		22b. ADDRESS <u>Riverlines MO</u>	
		22c. DATE SIGNED <u>5-26-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>May 27, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NEW HOPE CEMETERY.</u>		23d. LOCATION (City, town, or county) (State) <u>DUKEDONN TENN.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>RAYMOND CALDWELL & SONS</u> <u>FLAT RIVER, MO</u>		25. DATE RECD. BY LOCAL REG. <u>May 26, 1962</u>	
		26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</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 David P. Caldwell, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David P. Caldwell

Licensed Embalmer No. 5184

P. O. Address FLAT RIVER, 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.