

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-021758  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 373 Primary Registration District No. 6265 Registrar's No. 30

**FILED MAY 28 1962**

VS 300  
Rev. 4/59

1 120  
2 1120  
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4 0  
5 1  
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9 416X  
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12 90-2  
13 3-0

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 <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>GRANT</b> Length of stay in lb <b>6 Mo</b>		c. CITY OR TOWN <b>MARSHFIELD</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4 MI WEST</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4 MI WEST</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GLENN ROY DAY</b>			4. DATE OF DEATH Month Day Year <b>MAY 12 1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-16-1931</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CREDIT MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>30</b> IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME <b>ROY LEE DAY</b>		11b. MOTHER'S MAIDEN NAME <b>MARY BESSIE DAY</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) <b>YES KOREAN</b>		16. SOCIAL SECURITY NO. <b>PAULA SUE DAY MARSHFIELD</b>	
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) <b>CIRCULATORY FAILURE</b>			
DUE TO (b) <b>CORONARY THROMBOSIS</b>			
DUE TO (c) <b>RHEUMATIC HEART DISEASE (OLD)</b>			
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 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 <b>about 11:58 A.M.</b> to <b>Public Health Officer</b> and last saw him alive on <b>about 11:58 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>[Signature]</b> (Degree or title)		22b. ADDRESS <b>Marshallfield, Mo.</b>	22c. DATE SIGNED <b>5/17/62</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-15-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MISSION HOME</b>	23d. LOCATION (City, town, or county) <b>WEBSTER CO MO</b>
24. FUNERAL DIRECTOR <b>BARBER-EDWARDS, MARSHFIELD</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>5-24-62</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

JUN 26 1962

JUN 4 1962

MAY 28 1962

**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 *W. B. Barber*

Licensed Embalmer No. 3847

P. O. Address W. B. Barber 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.