

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022201

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 151

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 2 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>34 years</u>		c. CITY OR TOWN <u>Elsberry</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lilly</u> Middle <u>Moore</u> Last <u>Moore</u>			4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>62</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</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>1889 ?</u>	9. AGE (last birthday) <u>73 ?</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (City and state or country) <u>America</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>unk</u>		13b. MOTHER'S MAIDEN NAME <u>unk</u>	
14. NAME OF HUSBAND OR WIFE <u>unk</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>State Hospital records</u>		Address <u>Fulton, 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>Pulmonary infarction with embolism apparently from legs.</u>					
DUE TO (b) <u>Stasis Ulcers of left leg and right leg.</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____					
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. 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.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Hospital No. 1</u>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>State Hospital No. 1</u>		20g. COUNTY <u>Fulton</u>	
20h. STATE <u>Mo</u>		20i. DATE <u>5/17/1928</u> to <u>6/27/62</u>		20j. and last saw him alive on <u>XXXXXX</u>	
21. X attended the deceased from <u>State Hospital No. 1</u> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at <u>5:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R.C. Roberts</u>			22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo.</u>		22c. DATE SIGNED <u>6/27/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6-28-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jefferson City</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson City Mo</u>	
24. FUNERAL DIRECTOR <u>Thorpe T. Gordon</u>		ADDRESS <u>Jefferson City</u>		25. DATE RECD. BY LOCAL REG. <u>June 28-1962</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>

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 Gene B. Hewitt

Licensed Embalmer No. 4739

P. O. Address Jefferson City, 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.