

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022326

STATE FILE NUMBER

Registration District No. 3012 Primary Registration District No. 3012 Registrar's No. 63

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1 6001

2 0890

3 2

4 1

5 2

6

7 0

8 2

9 9040

10 21

11 600

12 86-0

13 1-1

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>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in lb <u>9 months</u>	c. CITY OR TOWN <u>Lawson, Missouri</u>		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>Spa-View Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u>		
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>E. James</u> Last <u>James</u>			4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-26-1873</u>	9. AGE (last birthday) <u>89</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>near Richmond, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Robert Denton</u>		13b. MOTHER'S MAIDEN NAME <u>Martha ?</u>		14. NAME OF HUSBAND OR WIFE <u>William James</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 Address <u>200 Miller St.</u> <u>Alice Richards, Excelsior Springs, 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>pneumonitis</u>					<u>sev. days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
DUE TO (b) <u>congestive heart failure</u>					<u>sev. week</u>	
DUE TO (c) <u>fracture left femur</u>					<u>6 mos.</u>	
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 checked="" 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.) <u>Fell in home</u>			
20c. TIME OF INJURY Hour <u>12</u> Month, Day, Year <u>26/61</u> a.m. p.m.	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 <u>Excelsior Springs, Clay, Missouri</u>		STATE	
21. I attended the deceased from <u>Dec. 26, 1961</u> to <u>June 7, 1862</u> and last saw her ^{her} alive on <u>June 7, 1962</u> Death occurred <u>6:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>M. D. Brock</i>			22b. ADDRESS <u>M. D. Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>7/7/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6-9-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawson</u>		23d. LOCATION (City, town, or county) (State) <u>Lawson, Mo.</u>		
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>7/7/62</u>	26. REGISTRAR'S SIGNATURE <i>Caroline Hutchings</i>			

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

Louise Jarman

Licensed Embalmer No. 4589

P. O. Address

Excelsior Springs, 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.