

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-022441
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 93 Primary Registration District No. _____ Registrar's No. 62-30

FILED JUN 18 1962

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cedar Rwp.</u> Length of stay in lb <u>60 yr</u>		c. CITY OR TOWN <u>Lockwood, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>12 N. North Lockwood</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>12 N. North Lockwood</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>OLLIE-FRANCES - FITE</u>			4. DATE OF DEATH Month Day Year <u>6-2-1962</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-20-1889</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeping</u>	11. BIRTHPLACE (City and state or country) <u>Jerico Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joshua Bays</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Martin</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Johanne Fyke, Lockwood, Mo.</u> Address <u></u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u></u>		
DUE TO (c) <u></u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>History of cerebral hemorrhage 2 yrs ago.</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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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.) <u>after death</u>	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>after death</u> to <u></u> and last saw her/him alive on <u></u>	Death occurred at <u>8:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>W.R. Allison Coomer</u>	22b. ADDRESS <u>Greenfield Mo</u>	22c. DATE SIGNED <u>6-3-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6-4-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedarville Cem</u>	23d. LOCATION (City, town, or county) (State) <u>6 N. S.E. Jerico Mo.</u>
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24. FUNERAL DIRECTOR <u>A. D. Long, Jerico Mo.</u> ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>6/11/1962</u>	26. REGISTRAR'S SIGNATURE <u>J.C. Canada</u>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

W.R. Allison Coomer

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 Ph. D. Long

Licensed Embalmer No. 8714

P. O. Address Jerico Sta. 7th

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.