

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-022670

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1017

FILED JUL 9 1962

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in lb 6 DAYS	c. CITY OR TOWN NIANGUA STAR RT Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in Hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5 MI EAST Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLETA Middle REESE Last			4. DATE OF DEATH Month JUNE Day 29 Year 1962
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-13-1916 9. AGE (last birthday) 45 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI 12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME RALPH CHAIR		13b. MOTHER'S MAIDEN NAME PEARL DUDLEY	14. NAME OF HUSBAND HERMAN
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	17. INFORMANT HERMAN REESE NIANGUA MO Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism from pelvic thrombophlebitis DUE TO (b) Internal cerebral Occlusion due to Arteriosclerosis DUE TO (c) with Right Hemiplegia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 20 min 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary arteriosclerosis without infarction			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 checked="" 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 6-24-62 to 6-29-62 and last saw her/him alive on 6-29-62 Death occurred at 10:15 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leola R. Turner MD		22b. ADDRESS 608 S Blustan Springfield, Mo	22c. DATE SIGNED 7-3-62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED	23b. DATE 6-28-1962	23c. NAME OF CEMETERY OR CREMATORY COPENING	23d. LOCATION (City, town, or county) (State) WEBSTER Co MO
24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD		25. DATE RECD. BY LOCAL REG. 7-5-62	26. REGISTRAR'S SIGNATURE Effie E. Melton

DATE AMENDED
INSTEAD OF
DOCUMENT
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
SHOULD READ
BY AFFIDAVIT OF

VS 300
Rev. 4/59
1 0397
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Cecil Auner, M.D.
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 *[Handwritten Signature]*

Licensed Embalmer No. 7848

P. O. Address *[Handwritten Address]*

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.

Permit issued 6-27-63