

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-022810

STATE FILE NUMBER

Registered District No. 141 Primary Registration District No. 3425 Registrar's No. 116

FILED JUL 17 1962

DO NOT WRITE ON THIS STUB

AMENDED

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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

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>years</u>		c. CITY OR TOWN <u>West Plains</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>W. P. Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Mask Rest Home</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James William</u> Middle <u>Duncan</u> Last <u>Duncan</u>			4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1962</u>		
5. SEX <u>male</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>10/25/1874</u>	9. AGE (last birthday) <u>87 years</u>	IF UNDER 1 YEAR Months <u>      </u> Days <u>      </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Osage Co., Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Robert M. Duncan</u>		13b. MOTHER'S MAIDEN NAME <u>Melinda Cheney</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Helen Williams, Gardena, Calif.</u> Address			
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>Congestive Heart Failure</u>					<u>48 hrs</u>
DUE TO (b) <u>Uremia</u>					<u>4 days</u>
DUE TO (c) <u>Arteriosclerosis, generalized</u>					<u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Melena etiology undetermined</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
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 <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.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>      </u> STATE <u>      </u>	
21. I attended the deceased from <u>June 7, 1962</u> to <u>June 11, 1962</u> and last saw <u>him</u> alive on <u>June 11, 1962</u> Death occurred at <u>4:55 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Murray T. Pritchard M.D.</u>			22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>6/14/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>6/15/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town, or county) <u>West Plains, Mo.</u> (State)
24. FUNERAL DIRECTOR <u>Robertson's, West Plains, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7-6-62</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

**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 AAR Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.