

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-023770

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 172

Primary Registration District No. 3034

Registrar's No. 49

STATE FILE NUMBER

FILED JUL 10 1962

VS 300	DATE AMENDED
Rev. 4/59	
1 0541	
2 0540	
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9 9000	INSTEAD OF
10 21	
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	DOCUMENT
	BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Higginsville</u>		Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>Higginsville</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>Park View Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 Mi. West</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Letitia</u> Middle <u>Florence</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (last birthday) <u>81</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <u>Higginsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Francis Gray</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Gray</u>	
14. NAME OF HUSBAND OR WIFE <u>none</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 <u>Wm. Gray</u> Address <u>Higginsville, Mo.</u>	
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>Broncho pneumonia</u> DUE TO (b) <u>Contusions to chest and extremities</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Severe generalized arteriosclerosis and a.s.h.d.</u>			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 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>The patient fell down a flight of stairs</u>	
20c. TIME OF INJURY <u>9:25 a.m. 6 25 62</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>In Home</u>	20f. CITY, TOWN, OR LOCATION <u>Higginsville Lafayette Mo.</u>	COUNTY STATE
21. I attended the deceased from <u>19 55</u> to <u>6-30-62</u> and last saw her alive on <u>6-29-62</u> Death occurred at <u>3:40 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wilbur E. Fulperson M.D.</u>		22b. ADDRESS <u>Higginsville Mo.</u>	22c. DATE SIGNED <u>7-4-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-2-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City</u>	23d. LOCATION (City, town, or county) (State) <u>Higginsville Missouri</u>
24. FUNERAL DIRECTOR <u>Forrest A. Hoefler</u> ADDRESS <u>Higginsville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>July 6, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Lutie Gordon Jordan</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 Forest R. Hoefler

Licensed Embalmer No. 4358

P. O. Address Higginsville, 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.