

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-023842

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 380 Primary Registration District No. 3099 Registrar's No. 126

FILED JUL 2 1962

VS 300
Rev. 4/59

1 0585
2 0580

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12 8-0

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BROOKFIELD</u>		Length of stay in lb <u>5 YRS</u>	c. CITY OR TOWN <u>PURDIN</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LOUISE'S REST HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>ELLIOTT</u> Last <u>HARRIS</u>			4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>62</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>9-26-84</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____
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 _____		11. BIRTHPLACE (City and state or country) <u>LUCERNE, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>WEL FORDYCE</u>		13b. MOTHER'S MAIDEN NAME <u>ALICE MARSHALL</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) <u>NO</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>MAUDE WOLFE, PURDIN, Mo.</u>		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) <u>Bacteremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
DUE TO (b) <u>Trophic ulcers</u>		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Malnutrition, senility</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	
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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 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 1962 to 1962 and last saw ^(her) him alive on 6-18-62
Death occurred at 12 Noon on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B. D. Aerial M.D. Brookfield, Mo.</u>	22b. ADDRESS <u>Brookfield, Mo.</u>	22c. DATE SIGNED <u>6-23-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-23-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>LINN COUNTY, MISSOURI</u>
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24. FUNERAL DIRECTOR <u>WRIGHTS - MEADVILLE, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-23-1962</u>	26. REGISTRAR'S SIGNATURE <u>Ann Wilson</u>
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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 W.R. Knight

Licensed Embalmer No. 4655

P. O. Address Madison, 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.