

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024085
STATE FILE NUMBER

Registration District No. 264 Primary Registration District No. 6292 Registrar's No. 32

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0770
2 0770,
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4 1
5 1
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7 1
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9 1750
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12 90-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED JUN 18 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>OZARK</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Thornfield Twp</u>		a. STATE <u>Mo</u> b. COUNTY <u>OZARK</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in lb <u>15 years</u>		c. CITY OR TOWN <u>LONGRUN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Alone Graves</u>		4. DATE OF DEATH Month Day Year <u>6-12-62</u>		d. STREET ADDRESS (If outside, give location) <u>6 miles North Highway 95</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1919</u>	9. AGE (last birthday) <u>43</u>	IF UNDER 1 YEAR IF UNDER 24 HR
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>Home</u>		11. BIRTHPLACE (City and state or country) <u>Wesley, Arkansas</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George Sisamore</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah F. Drake</u>		14. NAME OF HUSBAND OR WIFE <u>Sherwood Graves</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 Address <u>Sherwood Graves, Longrun, Mo</u>	
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>Aspiration Vomitus</u>				<u>3 min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Intestinal obstruction - debility.</u>				<u>7 day</u>	
DUE TO (c) <u>Carcinoma ovaries.</u>				<u>3 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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 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 <u>1-2-59</u> to <u>6-12-62</u> and last saw her alive on <u>6-12-62</u>		Death occurred at <u>7:20</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Arthur J. Beard, M.D.</u>		22b. ADDRESS <u>Grinesville, 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>Thornfield</u>		23d. LOCATION (City, town, or county) (State) <u>Ozark Co. Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Clinkingbeard, Grinesville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6/15/62</u>		26. REGISTRAR'S SIGNATURE <u>Lou Anna Wade</u>	

OCT 2 1962

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 John P. Unrey

Licensed Embalmer No. 4885

P. O. Address Greenwood 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.

Per permit of Howard OES