

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024137-  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 229

FILED JUN 18 1962

VS 300  
Rev. 4/59

10808

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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 <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>		Length of stay in 1b <b>12 years</b>	c. CITY OR TOWN <b>Sedalia</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2021 South Osage</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>H.</b> Last <b>Heard</b>			4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Agriculture</b>	9. AGE (last birthday) <b>82</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) <b>Johnson County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Columbus L. Heard</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Jane Shaw</b>	
14. NAME OF HUSBAND OR WIFE <b>Alta Nace Heard</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Alta Heard, 2021 South Osage Sedalia, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>Cerebral Vascular accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 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 <b>Sept 3-1957</b> to <b>6-11-62</b> and last saw her alive on <b>6-11-62</b> Death occurred at <b>4:45 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. R. Maddox M.D.</b> (Degree or title)		22b. ADDRESS <b>Sedalia Mo</b>	22c. DATE SIGNED <b>6-13-62</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/14/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>
24. FUNERAL DIRECTOR <b>W. Anderson</b> ADDRESS <b>Sedalia, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>6-13-62</b>	26. REGISTRAR'S SIGNATURE <b>W. Anderson, Deputy</b>

USE BLACK INK OR TYPEWRITER RIBBON

JUN 22 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 *Thomas Ewing*

Licensed Embalmer No. 38417

P. O. Address *Seaside, 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.