

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024310

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registered Death No. 314 Primary Registration District No. 664 Registrar's No. 39
FILED JUL 10 1962

VS 300
Rev. 4/59

10930
20930

3
4 0
5 2
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7 0
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9 527.1
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12 90-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola Township</u> Length of stay in lb <u>2 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4-m-S.W.Osceola</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u> c. CITY OR TOWN <u>Osceola</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" 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 Middle Last <u>Wallace - Farmer</u>		4. DATE OF DEATH Month Day Year <u>June 22, 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>5/28/89</u>	9. AGE (last birthday) <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Collings Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William C. Farmer</u>		13b. MOTHER'S MAIDEN NAME <u>Myrtle Pritchard</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. <u>None</u>	17. INFORMANT Address <u>Wallace Farmer Jr; Osceola 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>Euphysema - with</u> DUE TO (b) <u>toxemia -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ 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				INTERVAL BETWEEN ONSET AND DEATH <u>9 days 7</u>	
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 checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		20g. COUNTY	
20h. STATE		21. I attended the deceased from <u>6-20-62</u> to <u>6-22-62</u> and last saw him alive on <u>6-20-62</u> Death occurred at <u>10:45 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>Paul Seewers MD</u>		22b. ADDRESS <u>Osceola Mo</u>		22c. DATE SIGNED <u>6-29-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/26/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Goodrich Funeral Home, Osceola Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-24-62</u>	26. REGISTRAR'S SIGNATURE <u>Paul Seewers</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 J. B. [Signature]

Licensed Embalmer No. 3058

P. O. Address [Signature]

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.