

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025294
STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. **6240**

DO NOT WRITE ON THIS STUD

AMENDED

FILED JUL 2 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Lawrence		c. CITY OR TOWN Lawrenceville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1108 Lexington Avenue.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LEEFA OLIVE WAGGONER			First Middle Last			4. DATE OF DEATH JUNE 21 1962			Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/28/1902	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor			10b. KIND OF BUSINESS OR INDUSTRY Niagara Health Equipment, Lawrence Co. Ill.		11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY				
13a. FATHER'S NAME Charles Hutchinson			13b. MOTHER'S MAIDEN NAME Ellen Waggoner			14. NAME OF HUSBAND OR WIFE H. D. Waggoner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT H. D. Waggoner, 1108 Lexington Avenue., Lawrenceville, Illinois.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) INFECTIOUS HEPATITIS						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____						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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 JUNE 14, 1962 to JUNE 21, 1962 and last saw her/him alive on JUNE 21, 1962											
Death occurred at 3:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>E. J. Vanillon, M.D.</i>			(Degree or title) M. D.			22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 6/22/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/25/62	23c. NAME OF CEMETERY OR CREMATORY Summer City Cemetery		23d. LOCATION (City, town, or county) Lawrence County, Illinois.						
24. FUNERAL DIRECTOR Nichols Funeral Home, Lawrenceville, Illinois.				ADDRESS		25. DATE RECD. BY LOCAL REG. JUN 23 1962		26. REGISTRAR'S SIGNATURE <i>Roal Smith, M.D.</i>			

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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.