

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-026015

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 399

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 23 1962

VS 300 Rev. 4/59

1 0109
2 201092

3

4 0

5 1

6

7 0

8 1

9 4201

10

11

12 2-0

13 3-0

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>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BOONE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		Length of stay in 1b <u>12 days</u>	c. CITY OR TOWN <u>COLUMBIA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MISSOURI MEDICAL CENTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>705 WEST BLVD. SOUTH</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>EDWIN KARL GANOTE</u>			4. DATE OF DEATH Month Day Year <u>JULY 16, 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>OCT. 12, 1899</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>KING CITY, MISSOURI</u>
13a. FATHER'S NAME <u>JAMES R. GANOTE</u>		13b. MOTHER'S MAIDEN NAME <u>DORA WILLIAMS</u>	14. NAME OF HUSBAND OR WIFE <u>RUTH GANOTE</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>-</u>	17. INFORMANT Address <u>UNIVERSITY OF MISSOURI MEDICAL RECORDS</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>SHOCK AND PULMONARY EDEMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ANTERIOR SEPTAL MYOCARDIAL INFARCTION</u>			<u>10 DAYS</u>
DUE TO (c) <u>CORONARY ARTERY DISEASE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>diabetes mellitus</u>			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 a.m. p.m.	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>7-5-62</u> to <u>7-16-62</u> and last saw ^{her} <u>him</u> live on <u>7-16-62</u> Death occurred at <u>120</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Jack M. Martin M.D.</u>		22b. ADDRESS <u>M. U. Medical Center</u>	22c. DATE SIGNED <u>7/16/62</u>
23a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>	23b. DATE <u>7-18-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Albany Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Parker Funeral Service Columbia Mo</u>		25. DATE RECD. BY LOCAL REG. <u>July 17, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

USE BLACK INK OR TYPEWRITER RIBBON

JUL 25 1962

SEP 25 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

Donald L Roberts

Licensed Embalmer No.

4722

P. O. Address

Columbia 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.