

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-026854  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 139 Primary Registration District No. \_\_\_\_\_ Registrar's No. 44

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Holt</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oregon</u>		Length of stay in lb <u>3 months</u>	c. CITY OR TOWN <u>RFD # 1, Fillmore</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Brown Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 mile north</u>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>Leroy Wardlow</u>		Month Day Year <u>July 29, 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>8-14-82</u>
		9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	11. BIRTHPLACE (City and state or country) <u>Andrew County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Samuel Wardlow</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Wilkerson</u>		14. NAME OF HUSBAND OR WIFE <u>Floy B. Wardlow</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 <u>Donald Wardlow, Fillmore, Mo.</u>		Address	
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>Congestive myocardial failure</u>			<u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) <u>Acute Nephritis</u>			<u>2 months</u>
DUE TO (c) <u>Prostatitis</u>			<u>2 years</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 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>July 26/62</u> to <u>July 29/62</u> and last saw <sup>hear</sup> him alive on <u>July 29/62</u>			
Death occurred at <u>7:10 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. Bruce M. Roe MD</u>		22b. ADDRESS <u>Mound City Mo</u>	22c. DATE SIGNED <u>8/2/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>7-29-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fillmore Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fillmore, Missouri</u>
24. FUNERAL DIRECTOR <u>BREIT &amp; HAWKINS</u>	ADDRESS <u>SAVANNAH</u>	25. DATE RECD. BY LOCAL REG. <u>8-2-1962</u>	26. REGISTRAR'S SIGNATURE <u>Jamess H. Bradford</u>

VS 300 Rev. 4/59

1 0440

2 0020

3

4 0

5 2

6

7 0

8 2

9 611X

10

11

12 86-2

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James P. Hawkins

Licensed Embalmer No. 4536

P. O. Address Seaman

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.