

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-026876

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 122

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 16 1962	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> Length of stay in lb <u>8 days</u>	c. CITY OR TOWN <u>Pomona</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Newton</u> Last <u>Clow</u>	
4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>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>10/21/1889</u> 9. AGE (last birthday) <u>72 yrs</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 <u>farming</u>	
11. BIRTHPLACE (City and state or country) <u>Ewing, Lewis Co., Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Isaac Clow</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Clow</u>	
14. NAME OF HUSBAND OR WIFE <u>Pearl Briscoe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT Address <u>Mrs. J. N. Clow, Pomona, 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>Paralytic Ileus</u> DUE TO (b) <u>Post operative</u> DUE TO (c) <u>Appendiceal abscess</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General Debility</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 days</u> <u>6 days</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 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 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 <u>6-30-62</u> to <u>7-6-62</u> and last saw him alive on <u>7-6-62</u> Death occurred at <u>1:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>J. N. Clow</u> (Degree or title)	
22b. ADDRESS <u>West Plains, Missouri</u>	
22c. DATE SIGNED <u>7/9/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/8/1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Howell Memorial Park Cem., West Plains, Missouri</u>	
23d. LOCATION (City, town, or county) (State) <u>West Plains, Missouri</u>	
24. FUNERAL DIRECTOR <u>Robertson's, West Plains, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-12-62</u>
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

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 *A. P. Peterson*

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.