

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027500

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 112

FILED JUL 18 1962	
1. PLACE OF DEATH a. COUNTY <u>JASPER</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CARTHAGE</u> Length of stay in lb <u>4 MONTHS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OUR LADY OZARKS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>WEBSTER</u> c. CITY OR TOWN <u>SEYMOUR</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>SEYMOUR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>Mary</u> Last <u>BURDETT</u>	
4. DATE OF DEATH Month <u>7</u> - Day <u>9</u> - Year <u>62</u>	
5. SEX <u>FEMALE</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>Nov. 10, 1876</u> 9. AGE (last birthday) <u>85</u> IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Missouri</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN T. PAYNE</u> 13b. MOTHER'S MAIDEN NAME <u>EMMA REED</u> 14. NAME OF HUSBAND OR WIFE <u>DEC</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>NONE</u> 17. INFORMANT <u>MRS. PAUL R. STOCKSTILL</u> Address <u>JOPLIN, 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>Pulmonary embolism</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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 _____ 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 <u>3/14/62</u> to <u>7-9-62</u> and last saw her/him alive on <u>7/9/62</u> Death occurred at <u>2:55 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Charles L. Seibel, MD</u> (Degree or title) 22b. ADDRESS <u>1515 Hazel, Carthage, Mo.</u> 22c. DATE SIGNED <u>7/12/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE <u>7-11-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR MASONIC</u> 23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>Robert Bergman</u> <u>Seymour, Mo.</u> 25. DATE RECD. BY LOCAL REG. <u>7-9-62</u> 26. REGISTRAR'S SIGNATURE <u>W. J. Clifton</u>	

VS 300  
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

**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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield 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.