

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-027632

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 109

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED JUL 16 1962</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Johnson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Warrensburg</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Warrensburg Medical Center, Inc.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>116 W. South</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX	
First <b>Dennis</b> Middle <b>Lynn</b> Last <b>Larson</b>		Month <b>July</b> Day <b>13</b> Year <b>1962</b>		Male	
6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/14/60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		9. AGE (last birthday) <b>23 months</b>	
11a. BIRTHPLACE (City and state or country) <b>Warrensburg, Mo.</b>		11b. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13a. FATHER'S NAME <b>Lon E. Larson</b>		13b. MOTHER'S MAIDEN NAME <b>Doris J. Drinkwater</b>		14. NAME OF HUSBAND OR WIFE <b>--</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lon E. Larson, Warrensburg, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <b>Cardiac failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>	
DUE TO (b) <b>Tetralogy of Fallot</b>		DUE TO (c)		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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>Warrensburg</b>		COUNTY <b>Johnson</b>		STATE <b>Missouri</b>	
21. I attended the deceased from <b>3-9-62</b> to <b>7-13-62</b> and last saw him alive on <b>6-27-62</b>		Death occurred at <b>5:15 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>M.D.</b>	
22b. ADDRESS <b>Warrensburg, Missouri</b>		22c. DATE SIGNED <b>7/14/62</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>7/14/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Warrensburg, Missouri</b>	
24. FUNERAL DIRECTOR <b>Sweeney-Phillips, Warrensburg, Mo</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>July 14, 1962</b>	
25. REGISTRAR'S SIGNATURE <i>[Signature]</i>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		26. REGISTRAR'S SIGNATURE	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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 W. Raymond Baker

Licensed Embalmer No. 4616

P. O. Address Knob Noster, 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.