

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-027915

STATE FILE NUMBER

Registration District No. 227 Primary Registration District No. 5804 Registrar's No. 36

FILED JUL 23 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

10690

20690

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1286-0

131-0

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>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON</u>		Length of stay in 1b <u>4 YRS</u>	c. CITY OR TOWN <u>JACKSON TWP</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>PLEASANT VIEW REST HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2 mi EAST OF PARIS</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>DAISY DEENE CURTRIGHT</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>15</u> Year <u>1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12/18/1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER-FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL - FARM</u>	9. AGE (last birthday) <u>83</u> IF UNDER 1 YEAR: Mopths <u>6</u> Days <u>27</u> IF UNDER 24 HR: Hours <u>-</u> Min. <u>-</u>
13a. FATHER'S NAME <u>JOHN W. WILLS</u>		13b. MOTHER'S MAIDEN NAME <u>ALLIE JOHNSON</u>	14. NAME OF HUSBAND OR WIFE <u>MARK CURTRIGHT</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>ERA. W. DILLON, 982 EASTWOOD HARRISONVILLE 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>Cerebral embolism</u> DUE TO (b) <u>MI</u> DUE TO (c) <u>MI</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>21/5</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 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>3-2-62</u> to <u>7/15/62</u> and last saw her <u>alive</u> on <u>7/14/62</u> Death occurred at <u>1:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>PARIS, Mo.</u>	22c. DATE SIGNED <u>7-15-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-17-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT HILL CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>5 mi. E. of PARIS, Mo</u>
24. FUNERAL DIRECTOR <u>E. H. AGNEW</u> ADDRESS <u>PARIS, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-15-62</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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 E. M. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, 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.