

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-027948

STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 7

DO NOT WRITE ON THIS STUB

AMENDED

100 Rev. 4/59

10720

20720

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1290-2

133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

FILED JUL 23 1962		1. PLACE OF DEATH a. COUNTY New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Catron		Length of stay in 1b 26 years		c. CITY OR TOWN Catron Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Home Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Albert Middle Vester Last Kell			4. DATE OF DEATH Month June Day 30 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1884	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months 10 Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensioner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Bardwell, Kentucky	
13a. FATHER'S NAME Joseph Kell		13b. MOTHER'S MAIDEN NAME Mary Flack		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Polly Kell-Catron, Mo. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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 _____ 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 6-27-62 , to 6-30-62 and last saw her/him alive on 6-30-62 Death occurred at 6:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>James O. Cameron D.O.</i> (Degree or title)			22b. ADDRESS <i>Lilbourn, Mo.</i>		22c. DATE SIGNED 6-30-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-2-1962	23c. NAME OF CEMETERY OR CREMATORY Mounds Park		23d. LOCATION (City, town, or county) (State) Lilbourn, Missouri	
24. FUNERAL DIRECTOR Ponder Funeral Home-Lilbourn, Mo. ADDRESS			25. DATE RECD. BY LOCAL REG. 7/3/62		26. REGISTRAR'S SIGNATURE <i>Dr. Desh Hunter, M.D.</i>

USE BLACK INK OR TYPEWRITER RIBBON

VS JUL 24 1962

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 David H. Pender

Licensed Embalmer No. 5030

P. O. Address Lithuan, 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.