

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-028010

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 264 Primary Registration District No. 5888 Registrar's No. 36

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 16 1962

VS 300
Rev. 4/59

6770

20770

3

4 0

5 0

6

7 0

8 2

93400

10

11

1290-2

132-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ozark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Big Creek Twp</u>		Length of stay in lb <u>Life</u>	c. CITY OR TOWN <u>Longrun</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 miles west Longrun</u>
3. NAME OF DECEASED (Type or print) First <u>Cecil</u> Middle <u>Clifford</u> Last <u>Robertson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Longrun Mo.</u>
13a. FATHER'S NAME <u>B.H. Robertson</u>		13b. MOTHER'S MAIDEN NAME <u>Pearl Holt</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>B.H. Robertson</u> Address <u>Longrun 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>Inanition</u> DUE TO (b) <u>Paralysis due to meningitis & influenza</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Possible multiple sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>43 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Possible multiple sclerosis</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 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 <u> </u> Month, Day, Year <u> </u> a.m. 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 COUNTY STATE
21. I attended the deceased from <u>March 2, 1960</u> to <u>July 7, 1962</u> and last saw her/him alive on <u>April 15, 1962</u> Death occurred at <u>1:05 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M.J. Hoerman D.D.</u>		22b. ADDRESS <u>Gainesville, Missouri</u>	22c. DATE SIGNED <u>7/12/62</u>
23a. BURIAL/CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-8-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Thornfield Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Thornfield Mo.</u>
24. FUNERAL DIRECTOR <u>Clinkingbeard</u> ADDRESS <u>Gainesville</u>		25. DATE RECD. BY LOCAL REG. <u>7/12/62</u>	26. REGISTRAR'S SIGNATURE <u>Lou Anna C Wade</u>

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 John P. Casey

Licensed Embalmer No. 4885

P. O. Address Genesville 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.

No permit obtained 5/28