

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

108-62-028064

STATE FILE NUMBER

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 108

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 23 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Perry</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>Perry</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Perryville</u>		c. CITY OR TOWN <u>Perryville</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Perry County Memorial Hospital</u>		Length of stay in lb <u>6 Days</u>	d. STREET ADDRESS (If outside, give location) <u>1112 W. Grand,</u>
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <u>Sarah</u>	Middle <u>Ena</u>	Last <u>Reiss</u>	Month <u>July</u>	Day <u>11</u>	Year <u>1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1887</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
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>Sanford, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wm. Sanford</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>John W. Reiss</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.		17. INFORMANT <u>Odell Reiss, Perryville, Mo.</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>		<u>1 h</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of Spine & Metastasis</u>	<u>3 mo.</u>
	DUE TO (c) <u>in lung & metastasis</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 checked="" 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> s.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u>
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 7-5-62 to 7-11-62 and last saw her live on 7-10-62.
Death occurred at 1:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph W. Lathrop MD</u>		22b. ADDRESS <u>Perryville Mo.</u>		22c. DATE SIGNED <u>7-11-62</u>
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>	23b. DATE <u>7-13-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crossroads Cemetery-Perryville, Mo., R.5</u>	23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR ADDRESS <u>Albert Bey, Perryville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-13-62</u>	26. REGISTRAR'S SIGNATURE <u>Joe J. Zoller</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
<u>6795</u>
<u>20795</u>
3
4 <u>1</u>
5 <u>1</u>
6
7 <u>0</u>
8 <u>2</u>
<u>9/96.2</u>
10
11
<u>12-1-2</u>
<u>13-1-0</u>

