

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-028148

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 278 Primary Registration District No. 5956 Registrar's No. 104

FILED AUG 8 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Pike | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Pike | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Paynesville | | Length of stay in 1b Life | c. CITY OR TOWN Paynesville Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) One mile East of Paynesville Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Sue Middle E. Last Canady | | | 4. DATE OF DEATH Month July Day 28 Year 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9/27/1893 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 9. AGE (last birthday) 68 |
| 13a. FATHER'S NAME John T. Canady | | 13b. MOTHER'S MAIDEN NAME Catherine L. Campbell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Albert B. Canady, Louisiana, 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 1 day |
| DUE TO (b) hypertensive cardiovascular disease | | | years |
| DUE TO (c) hypertension, stibology unknown | | | years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) pneumonia, RLL | | | 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 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 6:25 Month, Day, Year 6-25-62 | | | |
| 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 Clarksville, Mo. |
| 21. I attended the deceased from 6-25-62 to death and last saw ^{her} alive on 7-27-62 Death occurred at 9:30 PM on 6-25-62 the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Edmond H. Jackson, M.D. | | 22b. ADDRESS Clarksville, Mo. | 22c. DATE SIGNED 7-30-62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 30, 62 | 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | 23d. LOCATION (City, town, or county) (State) Clarksville, Mo. |
| 24. FUNERAL DIRECTOR Geo. M. Collier, Louisiana, Mo. | | 25. DATE RECD. BY LOCAL REG. July 30-62 | 26. REGISTRAR'S SIGNATURE Bernice Collier |

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 Geo M. Callier

Licensed Embalmer No. 3839

P. O. Address Louisiana, 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.