

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029786

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 356 Primary Registration District No. 6207 Registrar's No. 59

FILED JUL 18 1962

VS 300
Rev. 4/59

1 1070
2 1070
3 1
4 1
5 2
6
7 0
8 2
9 99020
10 21
11 107
12 90-2
13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lynch-twp.</u>		c. CITY OR TOWN <u>Licking</u>	
Length of stay in lb <u>life</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		d. STREET ADDRESS (If outside, give location) <u>6 mi. W of Licking Mo</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Alice Stone</u>			4. DATE OF DEATH Month Day Year <u>July 6, 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>3-25-1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (City and state or country) <u>Licking Mo</u>
13a. FATHER'S NAME <u>Isaiah Barnes</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Roberts</u>	14. NAME OF HUSBAND OR WIFE <u>Curt Stone Licking Mo</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>✓</u>	17. INFORMANT <u>Curt Stone Licking 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>Cardiac & pulmonary arrest</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>cachexia & debilitation</u>	
		DUE TO (c) <u>Severe Systemic Shock & Semibility</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fell out of bed & fractured rt hip joint</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.) <u>fell out of bed</u>	
20c. TIME OF INJURY Hour <u>7</u> Minute <u>55</u> p.m. Month, Day, Year <u>7-3-62</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <u>Relaxed</u>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>LICKING, TEXAS, MO.</u>		
21. I attended the deceased from <u>7:55</u> on <u>7-3-62</u> and last saw him alive on <u>July 6, 1962</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B. J. Myers D.O.</u> (Degree or title)		22b. ADDRESS <u>Licking, Mo.</u>	22c. DATE SIGNED <u>7-11-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-10-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Van Cleve Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Texas Co. Mo</u>
24. FUNERAL DIRECTOR <u>Smith Ferguson Licking Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>July 13-1962</u>	26. REGISTRAR'S SIGNATURE <u>Myrtle Craig</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 Erberto Ferguson

Licensed Embalmer No. 3945

P. O. Address Farming Md

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.