

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-029803

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 103

FILED JUL 31 1962

VS 300
Rev. 4/59

1080
2499

3
4 1
5 1
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7 1
8 2
94500

10
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12 93-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Length of stay in 1b <u>5yrs-11Mo.</u>	c. CITY OR TOWN <u>Joplin</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>State Hospital #3</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>2111 Sargent</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u>Fannie</u> Last <u>Felker</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-4-1898</u>
9. AGE (last birthday) <u>63 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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 <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Sheridan, Iowa</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Willis Graves</u>	
13b. MOTHER'S MAIDEN NAME <u>Fannie ?</u>		14. NAME OF HUSBAND OR WIFE <u>Udah Felker</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>None</u>	17. INFORMANT <u>Hospital Records - Nevada, Mo. St. Hospital</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>Broncho Pneumonia</u>			<u>2 Weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) _____			
DUE TO (c) <u>Generalized Arteriosclerosis</u>			<u>Years</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 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 _____ 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 <u>VIEWED</u> to <u>THE BODY</u> and last saw him <u>live</u> on <u>7-12-62</u> Death occurred at <u>8:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Gilolo Mungishi M.D.</u>		22b. ADDRESS <u>Nevada, Mo</u>	22c. DATE SIGNED <u>7-12-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>7-13-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	23d. LOCATION (City, town, or county) <u>Ottawa, Kansas</u>
24. FUNERAL DIRECTOR <u>Townsend Funeral Home, Nevada</u>		25. DATE RECD. BY LOCAL REG. <u>7-24-1962</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>

USE BLACK INK OR TYPEWRITER RIBBON

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

L. August Ferry

Licensed Embalmer No. 4960

P. O. Address Neuada, Missouri

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.