

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029870

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. \_\_\_\_\_ Registrar's No. 267

FILED SEP 4 1962

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DOCUMENT  
MEDICAL CERTIFICATION *Dr. M. S. Chase*  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Connelville</b>		c. CITY OR TOWN <b>Connelville</b>	
Length of stay in 1b <b>4 1/2 yrs</b>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt. 2, Novinger, Mo.</b>		d. STREET ADDRESS (If outside, give location) <b>Rt. 2, Novinger, Mo.</b>	
3. NAME OF DECEASED (Type or print) First <b>BARBARA</b> Middle <b>BLACKSMITH</b> Last <b>BLACKSMITH</b>		4. DATE OF DEATH <b>August 25 1962</b> Month <b>August</b> Day <b>25</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> <del>Never Married</del> <input type="checkbox"/> <del>Widowed</del> <input type="checkbox"/> <del>Divorced</del> <input type="checkbox"/>	8. DATE OF BIRTH <b>11/21/82</b>
9. AGE (last birthday) <b>79</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Lingo, Macon Co., Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U S</b>		13. FATHER'S NAME <b>Joe Rash</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Joe Blacksmith Sr.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Joe Blacksmith Sr.</b>		Address <b>Rt 2, Novinger, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Mins.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Myocardial failure</b>			<b>Mos.</b>
DUE TO (c) <b>Arteriosclerosis</b>			<b>Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension cardio vascular disease</b>			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 _____ 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 <b>December 1, 1961</b> to <b>July 6, 1962</b> and last saw her alive on <b>July 6, 1962</b> Death occurred at <b>9:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>A. D. M. Chase</i>		22b. ADDRESS <b>Kirksville, Mo.</b>	22c. DATE SIGNED <b>8/26/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-28-62</b>	23c. NAME OF CEMETERY OR CREMATION <b>Maple Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville, Adair, Mo.</b>
24. FUNERAL DIRECTOR <b>Foster Memorial Home, Kirksville, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-28-62</b>	26. REGISTRAR'S SIGNATURE <i>Doris W. Rattiff</i>

Permit issued Aug 28, 1962

H. D. McClaure, D.O.

SEP 18 1962

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 *Nova E. Foster*  
NOVA E. FOSTER

Licensed Embalmer No. 4742

P. O. Address Kirkville, 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.