

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-029999

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 27 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0101
2 0101
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4 1
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9 4200
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12 86-2
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED SEP 5 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Boone		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Centralia		a. STATE Missouri b. COUNTY Boone	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Way Nursing Home		Length of stay in lb 18 mons.		c. CITY OR TOWN Centralia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		d. STREET ADDRESS (If outside, give location) 441 South Collier Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
First Mary		Middle C.		Last Beatty Month August Day 22 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-6-1872	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months 7 Days 16 IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (City and state or country) Centralia, Mo. 12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME J. L. Smith		13b. MOTHER'S MAIDEN NAME Isadore Jay		14. NAME OF HUSBAND OR WIFE John Beatty, Dec'd	
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 Way Nursing Home -- Centralia, Mo. Address	
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) Atrioventricular Block - Complete					Fast.
DUE TO (b) Arteriosclerotic Heart Disease					Four years.
DUE TO (c) _____					
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.	
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 5-16-62 to 8-22-62 and last saw her alive on 8-15-62 . Death occurred at 5:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE J. B. Baker, M.D. (Degree or title)			22b. ADDRESS Centralia, Mo		22c. DATE SIGNED 8-24-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/24/62	23c. NAME OF CEMETERY OR CREMATORY Salt River		23d. LOCATION (City, town, or county) (State) Audrain County, Mo.
24. FUNERAL DIRECTOR Arnold Funeral Home -- Mexico, Mo. ADDRESS			25. DATE RECD. BY LOCAL REG. Aug. 29-1962		26. REGISTRAR'S SIGNATURE Maud Mc Bride

Issued Removal Permit (Information Pending) Aug-22/62
"As out of town" signed M.E. B. side

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 Kenneth E. Hayes

Licensed Embalmer No. 4890

P. O. Address Mexico, 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: