

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-030166

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE **43**

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. 3007 Registrar's No. 964

FILED SEP 4 1962

VS 300
Rev. 4/59

10128
20730

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9/20/62

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY NEW MADRID	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 13 DAYS	c. CITY OR TOWN LILBOURN Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA, HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) GEN. DEL. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE NMI MCCOY			4. DATE OF DEATH Month Day Year AUGUST 19 1962
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-9-00
9. AGE (last birthday) 61		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) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) DELHI LA.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME NELSON MCCOY	
13b. MOTHER'S MAIDEN NAME MARY F. WINTERS		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) YES (If yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA. HOSPITAL RECORDS, POPLAR BLUFF, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE			INTERVAL BETWEEN ONSET AND DEATH DAY - - -
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PULMONARY EMBOLUS			- - -
DUE TO (c) THROMBOSIS OF RIGHT ATRIUM			- - -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) TUBERCULOSIS, PULMONARY BILATERAL			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 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 Month, Day, Year a.m. p.m.	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 VA AUGUST 6, 1962 to AUGUST 19, 1962 and last saw her live on Death occurred at 8:13PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) DAVID J. MILLER, M.D., M.C.P., Pathologist		22b. ADDRESS VA. HOSPITAL POPLAR BLUFF, MO.	22c. DATE SIGNED 8-19-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-26-0962	23c. NAME OF CEMETERY OR CREMATORY Sandhill	23d. LOCATION (City, town, or county) (State) Near New Madrid, Mo.
24. FUNERAL DIRECTOR Ponder Funeral Home, Lilbourn, Mo.		25. DATE RECD. BY LOCAL REG. 8-30-1962.	26. REGISTRAR'S SIGNATURE Delora Graham

NOV 2 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 *Edward H. Ponder*

Licensed Embalmer No. 5730

P. O. Address *Lithonia, Ga*

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.