

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031622

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 30.33 Registrar's No. 158

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Laclede</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u> | | Length of stay in lb <u>25 yrs</u> | c. CITY OR TOWN <u>Lebanon</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>Wallace Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>460 Curry St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Goldia Ellen Hemphill</u> | | | 4. DATE OF DEATH Month Day Year <u>Aug. 14, 1962</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>12/27/1903</u> |
| 9. AGE (last birthday) <u>58</u> | | 10. UNDER 1 YEAR IF UNDER 24 HR Months Days 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>-</u> | 11. BIRTHPLACE (City and state or country) <u>Laclede Co. Mo. U. S. A.</u> |
| 12. CITIZEN OF WHAT COUNTRY | | 13. NAME OF HUSBAND OR WIFE | |
| 13a. FATHER'S NAME <u>James B. Roberts</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary E. Munkholland Oran</u> | |
| 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>no</u> | | 15. SOCIAL SECURITY NO. <u>[REDACTED]</u> | |
| 16. INFORMANT <u>Oran Hemphill</u> | | 17. ADDRESS <u>Lebanon Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wernia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetic arteriosclerosis</u> | | | <u>5 years</u> |
| DUE TO (c) <u>renal shutdown</u> | | | <u>5 days</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>April 1962</u> to <u>Aug. 14, 1962</u> and last saw her <u>alive</u> on <u>Aug. 14, 1962</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 (Degree or title) <u>M. D. Harrington M.D.</u> | | 22b. ADDRESS <u>Lebanon, Mo.</u> | 22c. DATE SIGNED <u>8-16-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>8/16/1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Home</u> | 23d. LOCATION (City, town, or county) (State) <u>near Falcon, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Dorsey M. Howe</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-16-1962</u> | 26. REGISTRAR'S SIGNATURE <u>Hella L. Day</u> |

USE BLACK INK OR TYPEWRITER RIBBON

1962 AUG 21 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 Worsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.

Permit issued 8-16-1962 W.S.M.