

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

315-62-033541
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 315

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

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Stickler Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>507 E. Washington</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie Jane Selby</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/1/1874</u>
9. AGE (last birthday) <u>87</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>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Adair Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. NAME OF HUSBAND OR WIFE	
13a. FATHER'S NAME <u>Thomas Morrow</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Crist</u>	
14. NAME OF DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		15. SOCIAL SECURITY NO. <u>None</u>	
16. INFORMANT <u>Hayes Selby</u>		Address <u>Liberty, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>			<u>5 years</u>
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. <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 _____ 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 <u>November 17, 1959</u> to <u>October 7, 1962</u> and last saw her alive on <u>Oct. 7, 1962</u> Death occurred at <u>12:35</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ro Stickler MD</u>		22b. ADDRESS <u>107 E. Harrison Kirksville, Missouri</u>	22c. DATE SIGNED <u>10-8-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-9-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>	23d. LOCATION (City, town, or county) (State) <u>Macon Missouri</u>
24. FUNERAL DIRECTOR <u>R. J. [Signature]</u>		ADDRESS <u>Macon, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-10-1962</u>
26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>			

USE BLACK INK OR TYPEWRITER RIBBON

Permit renewed Oct 7, 1962

R. O. STICKLER, M.D.

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 R. Lester Brown

Licensed Embalmer No. 4472

P. O. Address Macop, 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.