

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033658

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 569

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

10109

20800

3

4 0

5 1

6

7 0

8 1

9 2002C

10

11

12 2-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>BOONE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>PETTIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>COLUMBIA</b>		Length of stay in lb <b>2 1/2 months</b>	c. CITY OR TOWN <b>SEDALIA</b>
d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>U.M.M.C.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE # 5</b>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>BROWN</b>			4. DATE OF DEATH Month <b>OCT.</b> Day <b>8</b> Year <b>1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-30-11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>FRANKLIN, MO.</b>
13a. FATHER'S NAME <b>JOHN W. BROWN SR.</b>		13b. MOTHER'S MAIDEN NAME <b>MARY COX</b>	14. NAME OF HUSBAND OR WIFE <b>VIOLET BROWN</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.	17. INFORMANT <b>Hospital Record UMMC</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC AND RESPIRATORY ARREST.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CONGESTIVE FAILURE</b>			<b>10 HRS ±</b>
DUE TO (c) <b>MALIGNANT LYMPHOMA</b>			<b>INDETERMINATE</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>SEPTISEMIA AND BOILS.</b>			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 checked="" type="checkbox"/> 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 _____ s.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>JULY 20, 1962</b> to <b>OCT 8, 1962</b> and last saw her alive on <b>OCT 8, 1962</b> Death occurred at <b>5:00 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John M. Laird, M.D.</b>		22b. ADDRESS <b>M.U. Medical Center</b>	22c. DATE SIGNED <b>10-8-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-10-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cem</b>	23d. LOCATION (City, town, or county) <b>Sedalia Mo.</b>
24. FUNERAL DIRECTOR <b>Duane Living</b>		25. DATE RECD. BY LOCAL REG. <b>Oct 8 1962</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>

USE BLACK INK OR TYPEWRITER RIBBON

OCT 16 1962

NOV 1 1962

OCT 24 1962

FEB 25 1963

**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. E. Baker

Licensed Embalmer No. 2419

P. O. Address Sedalia, 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.