

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033896

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 981

VS 300
Rev. 4/59

10128
2/20

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

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 BUTLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 408 DAYS	c. CITY OR TOWN QULIN 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 JAMES Middle WYLEY Last FLOWERS			4. DATE OF DEATH Month SEPTEMBER Day 2 Year 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-28-95
9. AGE (last birthday) 67		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) STEELE, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JAMES FLOWERS	
13b. MOTHER'S MAIDEN NAME ELZADA WAY		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 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) CHRONIC COR PULMONALE 9/2/62			INTERVAL BETWEEN ONSET AND DEATH 1 Year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA 9/2/62			6 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. <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 July 21, 1961 to Sept 2, 1962 Death occurred at 11:32 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert S. Cohen</i> ROBERT S. COHEN, M.D. Chief, Med Svc.		22b. ADDRESS VA. HOSPITAL POPLAR BLUFF, MO.	22c. DATE SIGNED 9-5-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 5, 1962	23c. NAME OF CEMETERY OR CREMATORY Browns Chapel Cemetery Broseley Missouri	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS Landess Funeral Home, Campbell, Mo.		25. DATE RECD. BY LOCAL REG. 9-11-1962	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>

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

Christine L. Beall

Licensed Embalmer No. 4227

P. O. Address

Campbell, 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.