

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033906

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. 1018

FILED OCT 9 1962

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Rev. 4/59.

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SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 ARKANSAS b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in lb 55 DAYS	c. CITY OR TOWN ST. FRANCIS 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) GENERAL DELIVERY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OSCAR Middle MERRITT Last LAMP			4. DATE OF DEATH Month SEPTEMBER Day 19 Year 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-1-89
9. AGE (last birthday) 73		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) BLACKSMITH		10b. KIND OF BUSINESS OR INDUSTRY BLACKSMITH	11. BIRTHPLACE (City and state or country) CARMI, ILLINOIS
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JOHN LAMP	
13b. MOTHER'S MAIDEN NAME ROSIE CRAVINS		14. NAME OF HUSBAND OR WIFE MINNIE LAMP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT VA HOSPITAL RECORDS, POPLAR BLUFF, MO. Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM			INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) THROMBOPHLEBITIS LEFT LEG			2 MONTHS
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 VA COUNTY _____ STATE _____
21. I attended the deceased from JULY 26, 1962 to SEPTEMBER 19, 1962 Death occurred at 12:02 P m 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 MD Chief Medical Service		22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 9-28-62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-22-62	23c. NAME OF CEMETERY OR CREMATORY CUMMINGS CHAPEL	23d. LOCATION (City, town, or county) PIGGOTT, ARK RT # 1
24. FUNERAL DIRECTOR RUSSELL MORTUARY PIGGOTT, ATK	25. DATE RECD. BY LOCAL REG. 10-5-1962	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 me, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Gerald W. Hoggans

Licensed Embalmer No. 1116

P. O. Address Payroll

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.