

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034042
STATE FILE NUMBER

Registration District No. 05 Primary Registration District No. 3011 Registrar's No. 108

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

| | | | | | |
|---|--|---|--|--|--|
| FILED SEP 24 1962 | | 1. PLACE OF DEATH a. COUNTY <u>CARROL</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>SALINE</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CARROLton</u> | | Length of stay in 1b | | c. CITY OR TOWN <u>MALTA BEND</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WETZEL HOSP.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>PO BOX</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>KATE</u> Middle <u>A.</u> Last <u>SPORTSMAN</u> | | 4. DATE OF DEATH <u>9-10-1962</u> | | Month Day Year | |
| 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>4-2-1879</u> | | 9. AGE (last birthday) <u>83</u> | | IF UNDER 1 YEAR IF UNDER 24 HR Months <u>5</u> Days <u>8</u> Hours <u></u> Min. <u></u> | |
| 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>HOME</u> | | 11. BIRTHPLACE (City and state or country) <u>CHARITON Co. Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>JOHN S. WYATT</u> | | 13b. MOTHER'S MAIDEN NAME <u>HANNAH PENROD</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>HUGH SPORTSMAN</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>WALLACE WYATT</u> | | Address <u>MALTA BEND Mo.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia (Pneumonia)</u> (b) <u>Cerebral Hemorrhage</u> (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | |
| 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 | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>9/5/62</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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>Sept 5-62</u> to <u>Sept 10-62</u> last saw her alive on <u>Sept 10-62</u> Death occurred at <u>11:45 P</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) <u>Leo Jones</u> | |
| 22b. ADDRESS <u>112 Overly</u> | | 22c. DATE SIGNED <u>9/12/62</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | |
| 23b. DATE <u>7-15-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>STANLY CEM.</u> | | 23d. LOCATION (City, town, or county) <u>CHARITON Co. Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>MILLER-Tillotson</u> | | ADDRESS <u>Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>9-14-62</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Bill Momm Kemp</u> | | | | | |

USE BLACK INK OR TYPEWRITER RIBBON

mod 2 (Student signed) 10/2/10

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 Lillian K. Tielatson

Licensed Embalmer No. 4508

P. O. Address Marceline, 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.