

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034238

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 24 1962

Registration District No. 99

Primary Registration District No. _____

Registrar's No. _____

49

VS 300
Rev. 4/59

10320
20250

3
4 1
5 2
6
7 0
8 0
94201
10
11
12 86-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY De Kalb			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clinton		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maysville		Length of stay in lb 10 mo.	c. CITY OR TOWN Plattsburg		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunset Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ida Middle J. Last CRAWF			4. DATE OF DEATH Month Sept. Day 14 Year 1962		
5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/17/1870	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Keeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Maysville, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME August Warrens		13b. MOTHER'S MAIDEN NAME Amanda Kessler		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NINE		17. INFORMANT Address Mrs. John Jackson, Plattsburg 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) Cardiac failure due to Coronary atherosclerosis					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		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 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 JAN 1962 to SEPT 4, 1962 and last saw her alive on Sept 4, 1962 . Death occurred at 10 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J. S. Weiger M.D.			22b. ADDRESS Maysville, Mo		22c. DATE SIGNED 8/6/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-6-62	23c. NAME OF CEMETERY OR CREMATORY Green Lawn		23d. LOCATION (City, town, or county) (State) Plattsburg, Mo.	
24. FUNERAL DIRECTOR Lyon Funerat Home, Plattsburg, Ms.		ADDRESS		25. DATE RECD. BY LOCAL REG. 9-16-62	26. REGISTRAR'S SIGNATURE Gerlie E. Davidson

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was~~ ^{will be} embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Phillip E. Cox

Licensed Embalmer No. 4993

P. O. Address Plantersburg, 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.