

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034256

STATE FILE NUMBER

Registration District No. 101 Primary Registration District No. _____ Registrar's No. 38

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 1 1962

1. PLACE OF DEATH a. COUNTY <u>DOUGLAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <u>MO.</u> b. COUNTY <u>WRIGHT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CASS TOWNSHIP</u>		Length of stay in 1b <u>2 WKS</u>	c. CITY OR TOWN <u>MANSFIELD</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt 2 Ridens Res. NORWOOD</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE LIZZIE FAGAN</u>			4. DATE OF DEATH Month Day Year <u>Sept. 19 1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>Dec. 23, 1883</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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>—</u>		11. BIRTHPLACE (City and state or country) <u>R.R. NORWOOD MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>MARCELLUS ALLEN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY WELLS</u>		14. NAME OF HUSBAND OR WIFE <u>Ed C.</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>MRS. ROSIE RIDENS Rt 2 NORWOOD MO</u> 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) <u>CORONARY OCCLUSION</u>	INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CORONARY THROMBOSIS & MYOCARDIAL INFARCTION</u>	<u>2 weeks.</u>
DUE TO (c) <u>ARTERIOSCLEROSIS</u>	<u>undetermined</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
P.:

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 <u>Sept 9, 1962</u> to <u>Sept 19, 1962</u> and last saw her <u>alive on Sept 19, 1962</u> Death occurred at <u>8:35 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

21. SIGNATURE (Degree or title) <u>Richard M. Mitchem DO</u>		22b. ADDRESS <u>Mountain Home, Mo</u>		22c. DATE SIGNED <u>9-24-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-22-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wolf Creek</u>		23d. LOCATION (City, town, or county) (State) <u>WRIGHT COUNTY MO.</u>
24. FUNERAL DIRECTOR <u>Max & Miller</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 27-62</u>		26. REGISTRAR'S SIGNATURE <u>Vestal Bushman</u>

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

USE BLACK INK OR TYPEWRITER RIBBON

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manfield 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.