

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034282

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 116 Primary Registration District No. 3030 Registrar's No. 208

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 8 1962

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Hosp.</u>		Length of stay in 1b <u>4 hrs</u>	c. CITY OR TOWN <u>Augusta</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R R 1</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>OLIVER M. FOX</u>			4. DATE OF DEATH Month Day Year <u>OCT 5 1962</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/01</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>Oakdale Ill</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>William Fox</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Bahlw</u>	

14. NAME OF HUSBAND OR WIFE <u>Edna Fox</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>	
17. INFORMANT <u>Edna Fox</u>		Address <u>Augusta Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Heniplegia</u>			<u>1 day</u>
DUE TO (b) <u>Hypertension</u>			<u>unknown</u>
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	
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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.)	
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
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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
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21. I attended the deceased from Oct 5/62 to Oct 5/62 and last saw her/him alive on Oct 5/62
Death occurred at 4:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J.C. Johnson M.D.</u> (Degree or title)	22b. ADDRESS <u>Marthorville mo</u>	22c. DATE SIGNED <u>10/6/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-8-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	23d. LOCATION (City, town, or county) <u>Carletonville Ill</u>
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24. FUNERAL DIRECTOR <u>T.E. Tetman</u>	ADDRESS <u>Wentzville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10/6/62</u>	26. REGISTRAR'S SIGNATURE <u>Lois G. Heidmann</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
0365
3920
3
4 0
5 1
6
7 1
8 0
9334X
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11
12 0
13 5-0

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

OCT 30 1962

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 Olie Thiering

Licensed Embalmer No. 3759

P. O. Address Augusta 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.