

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034363

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1432

FILED SEP 6 1962

<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>GREENE</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Length of stay in lb <u>8 WKS</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE HOSP</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u></p> <p>c. CITY OR TOWN <u>MARSHFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>631 E. JACKSON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>					
<p><b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>RUTH JANE DAVIS</u></p>		<p><b>4. DATE OF DEATH</b> Month Day Year <u>SEPT 30, 1962</u></p>					
<p><b>5. SEX</b> <u>FEMALE</u></p>	<p><b>6. COLOR OR RACE</b> <u>WHITE</u></p>	<p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>5-23-1927</u></p>	<p><b>9. AGE</b> (last birthday) <u>35</u></p>	<p><b>IF UNDER 1 YEAR</b> Months Days</p>	<p><b>IF UNDER 24 HR</b> Hours Min.</p>	
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____</p>		<p><b>11. BIRTHPLACE</b> (City and state or country) <u>MISSOURI</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A</u></p>	
<p><b>13a. FATHER'S NAME</b> <u>WILLIAM ALEXANDER</u></p>		<p><b>13b. MOTHER'S MAIDEN NAME</b> <u>ESTHER LETTERMAN</u></p>		<p><b>14. NAME OF HUSBAND OR WIFE</b> <u>EUGENE</u></p>			
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b> _____</p>		<p><b>17. INFORMANT</b> <u>EUGENE DAVIS MARSHFIELD</u> Address _____</p>			
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>						<p><b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 year</u></p>	
<p>IMMEDIATE CAUSE (a) <u>Malignant Melanoma</u></p>							
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>with multiple metastases</u></p> <p>DUE TO (c) _____</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>						<p>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</p>	
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>		<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p><b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>		<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>		<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p><b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____</p>	
<p><b>21. I attended the deceased from</b> <u>7-28-62</u> to <u>9-21-62</u> and last saw her/him alive on <u>9-20-62</u>. Death occurred at <u>8:05 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p><b>22a. SIGNATURE</b> (Degree or title) <u>Clara R. Quinn MD</u></p>				<p><b>22b. ADDRESS</b> <u>6005 Illustone Springfield, Mo</u></p>		<p><b>22c. DATE SIGNED</b> <u>9-24-62</u></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>REMOVAL</u></p>		<p><b>23b. DATE</b> <u>9-21-1962</u></p>		<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MARSHFIELD</u></p>		<p><b>23d. LOCATION</b> (City, town, or county) <u>MARSHFIELD MO</u> (State)</p>	
<p><b>24. FUNERAL DIRECTOR</b> <u>BARBER-EDWARDS MARSHFIELD</u> ADDRESS _____</p>			<p><b>25. DATE RECD. BY LOCAL REG.</b> <u>9-25-62</u></p>		<p><b>26. REGISTRAR'S SIGNATURE</b> <u>Offie E. Mellen</u></p>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Cecilia Auner USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59  
6397  
21120  
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FEB 14 1963

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 George Staffe

Licensed Embalmer No. 318

P. O. Address Mt. Laurel, MD

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.

Permit 9-21-62