

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034425  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1363

<b>FILED SEP 17 1962</b>		
<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</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BAPTIST 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>SEYMOUR</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>ROUTE 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	
<p><b>3. NAME OF DECEASED</b> First Middle Last <u>Viona Minner</u></p>		
<p><b>4. DATE OF DEATH</b> Month Day Year <u>Sept-8-1962</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"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/></p>
<p><b>8. DATE OF BIRTH</b> <u>MAY 28 1899</u></p>		<p><b>9. AGE (last birthday)</b> <u>63</u></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> <u>GRAHAM CO. KANS.</u></p>
<p><b>11. BIRTHPLACE</b> (City and state or country) <u>U.S.A.</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u></p>
<p><b>13a. FATHER'S NAME</b> <u>JOHN STRATCH</u></p>		<p><b>13b. MOTHER'S MAIDEN NAME</b> <u>ELLEN JONES</u></p>
<p><b>14. NAME OF HUSBAND OR WIFE</b> <u>H.R. MINNER</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> <u>NONE</u></p>
<p><b>17. INFORMANT</b> <u>H.R. MINNER</u> Address <u>SEYMOUR, MO. RT 3</u></p>		
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u></p> <p>DUE TO (b) <u>Cerebral Arteriosclerosis</u></p> <p>DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u></p> <p><u>2 wks</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u></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 SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.</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> <u>Springfield, Mo</u></p>		<p>COUNTY <u>WEBSTER</u> STATE <u>MO.</u></p>
<p><b>21. I attended the deceased from</b> <u>Jan 16, 62</u> to <u>8 Sept 62</u> and last saw her alive on <u>8 Sept 62</u> Death occurred at <u>9:40 a.m.</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>E. C. Callaway, MD</u></p>		<p><b>22b. ADDRESS</b> <u>Springfield, Mo</u></p>
<p><b>22c. DATE SIGNED</b> <u>11 Sep 62</u></p>		
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u></p>		<p><b>23b. DATE</b> <u>9-11-62</u></p>
<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SEYMOUR MASONIC</u></p>		<p><b>23d. LOCATION</b> (City, town, or county) <u>WEBSTER CO. MO.</u></p>
<p><b>24. FUNERAL DIRECTOR</b> <u>Robert Bengman, Seymour, Mo.</u></p>		<p><b>25. DATE RECD. BY LOCAL REG.</b> <u>9-13-62</u></p>
<p><b>26. REGISTRAR'S SIGNATURE</b> <u>Effie S. Meeton</u></p>		

VS 300  
Rev. 4/59

10397  
21120  
3  
4 1  
5 1  
6  
7 1  
8 0  
9331X  
10  
11  
125-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Received 9-8-62

**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 Manassas 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.