

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034578

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 159

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 24 1962

VS 300
Rev. 4/59

10465
20460

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Lanton, Missouri</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Plains Memorial Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Juern</u> Last <u>Juern</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/1888</u>
9. AGE (last birthday) <u>76 years</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	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>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Howell County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles H. Juern</u>	
13b. MOTHER'S MAIDEN NAME <u>Dena Sparenburg</u>		14. NAME OF HUSBAND OR WIFE <u>Single</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>no</u>	17. INFORMANT <u>J. M. Juern, Koshkonong, Mo.</u>
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>Acute pulmonary edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive heart failure</u>			<u>1 year</u>
DUE TO (c) <u>Arteriosclerotic heart disease</u>			<u>2 years</u>
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 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 checked="" 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>1955</u> to <u>Sept. 16, 1962</u> and last saw her alive on <u>Sept 16, 1962</u>		Death occurred at <u>5:45 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>M.L. Fowler MD</u>		22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>9/17/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/19/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mint Springs Cemetery near Lanton, Missouri</u>	23d. LOCATION (City, town, or county)
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-17-62</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

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 *Leland Carter*

Licensed Embalmer No. 4516

P. O. Address *West Plains 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.