

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034580

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 168

FILED OCT 8 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
Rev. 4/59								
10465								
20460								
3								
4 0								
5 2								
6								
7 1								
8 2								
9 4200	SHOULD READ							
10	SHOULD READ							
11	SHOULD READ							
12 5-0	SHOULD READ							
13 1-0	SHOULD READ							

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 lb <u>24 hrs.</u>	c. CITY OR TOWN <u>West Plains, Missouri</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>West Plains Memorial Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Siloam Springs Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>James Leonard LaFavers</u>		First Middle Last	4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>9/15/1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (last birthday) <u>75</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11a. FATHER'S NAME <u>McCame LaFavers</u>		11b. MOTHER'S MAIDEN NAME <u>Tennessee Cole</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		12b. SOCIAL SECURITY NO.	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DIS</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel LaFavers, Deceased</u> Address <u>S.S. Route West Plains, Mo.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1. ARTERIOSCLEROSIS, GENERALIZED 2. Senility</u>		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 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>1957</u> to <u>10-4-62</u> and last saw him alive on <u>10-4-62</u> Death occurred at <u>11:40 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Jack N. Wiley, M.D. West Plains, Mo.</u>		22b. ADDRESS	22c. DATE SIGNED <u>10-5-62</u>
23a. BURIAL (CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 7, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calm Cometary</u>	23d. LOCATION (City, town, or county) <u>Fulton County, Arkansas</u>
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-5-62</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

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 Leland Carter

Licensed Embalmer No. 4576

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.