

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-037525

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 97

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

6030
B440

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94201

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY HATCHISON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY HOLT | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FAIRFAX | | Length of stay in lb 3 HRS. | c. CITY OR TOWN MOUND City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last BELINDA MAUDE WRIGHT | | | 4. DATE OF DEATH Month Day Year OCT. 9, 1962 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9/3/1880 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY IN THE HOME | 11. BIRTHPLACE (City and state or country) HOLT County, Mo. |
| 13a. FATHER'S NAME ROBERT CRAIG | | 13b. MOTHER'S MAIDEN NAME CLARA HODGE | 14. NAME OF HUSBAND OR WIFE CARL C. WRIGHT |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT Address MRS. GEORGE COTTON, FOREST CITY, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO (b) Peripheral Vascular Collapse DUE TO (c) Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH 4 min. 5 min. 2 hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) generalized arteriosclerosis | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 July 1959 to Oct 9, 1962 and last saw her alive on Oct 9, 1962 Death occurred at 11:45 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE James H. Crawford (Degree or title) | | 22b. ADDRESS Mound City, Mo. | 22c. DATE SIGNED Oct 11, 1962 |
| 23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 10-12-1962 | 23c. NAME OF CEMETERY OR CREMATORY DENTON CEMETERY | 23d. LOCATION (City, town, or county) (State) HOLT County, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS James H. Crawford Mound City, Mo. | | 25. DATE RECD. BY LOCAL REG. Oct. 12, 1962 | 26. REGISTRAR'S SIGNATURE Thermin A. Schoales |

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 James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Moond City, 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.