

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-032904

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 448 STATE FILE NUMBER

FILED OCT 22 1962

VS 300
Rev. 4/59

1 0168
2 0160
3
4 1
5 2
6
7 0
8 0
9 174X
10
11
12 3-0
13 1-0

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 <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Cape Gir</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> Length of stay in 1b		c. CITY OR TOWN <u>Rt. 4</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>Southeast Missouri</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>8 mi N.E. Jackson</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella Marcella Bennett</u>			4. DATE OF DEATH Month Day Year <u>Oct 13, 1962</u>
5. SEX <u>Female</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>4/20/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>72</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME <u>John M. Walker</u>		11b. MOTHER'S MAIDEN NAME <u>Sarah E. Jeffers</u>	11. BIRTHPLACE (City and state or country) <u>Oriole, Mo</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.	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
17. INFORMANT <u>Mrs. John Farrow Jr.</u>		14. NAME OF HUSBAND OR WIFE <u>W. E. Jackson</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>Sarcoma of uterus</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>6 mos.</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 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>5-19-53</u> and last saw her alive on <u>10-12-62</u> Death occurred at <u>6:22 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>D. H. Jager, M.D.</u> (Degree or title)		22b. ADDRESS <u>Jackson, Mo</u>	22c. DATE SIGNED <u>10-14-62</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>Oct 20, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McLains</u>	23d. LOCATION (City, town, or county) (State) <u>Oriole Mo.</u>
24. FUNERAL DIRECTOR <u>C. C. Raught</u> ADDRESS <u>Jackson, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-17-62</u>	26. REGISTRAR'S SIGNATURE <u>Gene Karter</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 *J. C. Craight*

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.