

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037934

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 474

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 7 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIBARDEAU</u>		Length of stay in 1b <u>11 DAYS</u>	c. CITY OR TOWN <u>CHAFFEE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CAPE OSTEOPATHIC HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>403 N. THIRD ST.</u>
3. NAME OF DECEASED (Type or print) First <u>LURA</u> Middle <u>EVELYN</u> Last <u>O'NAN</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>28</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1893</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HR Hours <u></u> Min. <u></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 <u>—</u>	11. BIRTHPLACE (City and state or country) <u>NEW HAVEN, ILL.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>LYMAN GOFORTH</u>	
13b. MOTHER'S MAIDEN NAME <u>SARAH DILLARD</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES M. O'NAN</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>NONE</u>	17. INFORMANT <u>EARL DUDLEY - CHAFFEE, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uremia</u>			<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>post surgical hip pinning</u>			<u>5 day</u>
DUE TO (c) <u>fractured hip</u>			<u>7 day</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 <u></u> a.m. <u></u> p.m. <u></u>	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>10/11/62</u> to <u>10/28/62</u> and last saw her/him alive on <u>10/28/62</u> Death occurred at <u>12:55</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Kenneth D. Bear D.O.</u>		22b. ADDRESS <u>Chaffee, Mo.</u>	22c. DATE SIGNED <u>10/28/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 29, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CHAFFEE, Missouri</u>
24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-1-62</u>	26. REGISTRAR'S SIGNATURE <u>James Kasten</u>

USE BLACK INK OR TYPEWRITER RIBBON

NOV 29 1962

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 Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, 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.