

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039464

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 35

FILED OCT 16 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Maries</u>		a. STATE <u>Mo</u> b. COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson township</u>		c. CITY OR TOWN <u>Jefferson township</u>	
Length of stay in lb <u>2 years</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>At Home</u>		d. STREET ADDRESS (If outside, give location) <u>South of Belle Mo.</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RODGER ARNOLD MAHANEY</u>			4. DATE OF DEATH Month Day Year <u>October 8, 1962</u>
5. SEX <u>Male</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>3/1/46</u>
9. AGE (last birthday) <u>16</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>student</u>	11. BIRTHPLACE (City and state or country) <u>Vichy Missouri U. S. A?</u>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>Ivan Mahaney</u>	
13b. MOTHER'S MAIDEN NAME <u>Mae Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>Ivan Mahaney, Belle 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>Crushed Head & Chest</u>			INTERVAL BETWEEN ONSET AND DEATH: <u>Instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 checked="" 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.) <u>Crushed in Farm Tractor accident</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>6:00 p.m.</u> Month, Day, Year <u>10/8/62</u>			
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.) <u>Farm</u>	20f. CITY, TOWN, OR LOCATION <u>Belle R.F.D.</u>	COUNTY <u>Maries</u> STATE <u>MO.</u>
21. I attended the deceased from <u>Home</u> to <u>10/8/62 6:00 p.m.</u> and last saw him alive on <u>None Instant Death</u>			
Death occurred at <u>6:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. H. Schomburg M.D.</u>		22b. ADDRESS <u>Belle Mo</u>	22c. DATE SIGNED <u>10/10/62</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/11/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Skaggs Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>Near Belle Mo</u>
24. FUNERAL DIRECTOR <u>Howard Jones Belle Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-11-1962</u>	26. REGISTRAR'S SIGNATURE <u>Mozelle Stetson</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 *Orme Howard Jones*

Licensed Embalmer No. *4491*

P. O. Address *Belle Me.*

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.