

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039925
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 445

FILED OCT 24 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

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. FRANCOIS TWP.</u>		Length of stay in 1b <u>4 DAYS</u>	c. CITY OR TOWN <u>HEMATITE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MINERAL AERA HOSP-</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <u>201 CHESTNUT ST.</u>
3. NAME OF DECEASED (Type or print) First <u>ALTA</u> Middle <u>ESTA</u> Last <u>MCCOY</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>18</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOK KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>76</u>
13a. FATHER'S NAME <u>JOHN O. MCCOY</u>		13b. MOTHER'S MAIDEN NAME <u>NORA SPURGIN</u>	11. BIRTHPLACE (City and state or country) <u>SNELBYVILLE, ILL.</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>
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>MYOCARDIAL ISCHEMIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SECONDS</u>	
DUE TO (c) <u>MASSIVE GASTRIC HEMORRHAGE</u>		<u>2.3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		PART III. If deceased was febrile 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 _____ 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>10-16-62</u> to <u>10-18-62</u> and last saw her/him alive on <u>10-18-62 @ 7⁰⁰ PM</u> Death occurred at <u>10:50 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>Ralph D. Cooper, D.O.</u>		22b. ADDRESS <u>Farmington Mo.</u>	22c. DATE SIGNED <u>10-20-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>	23d. LOCATION (City, town, or county) (State) <u>HEMATITE MO.</u>
24. FUNERAL DIRECTOR <u>James R. Cady</u> ADDRESS <u>Crystal City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 20, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</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 James Richard Cady

Licensed Embalmer No. 4309

P. O. Address CRYSTAL 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.