

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040383

318 Primary Registration District No. 1003 Registrar's No. 10074

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10074

FILED OCT 29 1962

VS 300 Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Laclede Co.		c. CITY OR TOWN Lebanon		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.R. #3 Lebanon Mo.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ZILAH Middle MAE Last KAFFENBERGER						4. DATE OF DEATH Month OCTOBER Day 19 Year 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 Aug. 4-1899		9. AGE (last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Laclede Co. Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Dan Davis				13b. MOTHER'S MAIDEN NAME Mary A. Shaw				14. NAME OF HUSBAND OR WIFE Raymond Kaffenberger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Raymond Kaffenberger R.R. 3 Lebanon 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) metastatic CA Rt Maxillary Antrum to the Brain										INTERVAL BETWEEN ONSET AND DEATH 9 months	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) CA of Rt Maxillary Antrum - 160.2	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 10-18-62 AM to 10-19-62 and last saw her alive on 10-19-62 Death occurred at 6pm 10-19-62 m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Robert H. Samuel M.D.						22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 10-20-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-20-1962		23c. NAME OF CEMETERY OR CREMATORY Lebanon City Cemetery			23d. LOCATION (City, town, or county) Lebanon, Missouri			(State)	
24. FUNERAL DIRECTOR ADDRESS Palmer Funeral Home, Lebanon, Mo.						DATE RECD: BY LOCAL REG. OCT 22 1962		25. REGISTRAR'S SIGNATURE Road Smith, M.D.			

OCT 29 1962

MISSOURI STATE BOARD OF HEALTH
ST. LOUIS, MISSOURI

NAME: _____ SEX: _____

DATE OF BIRTH: _____

RESIDENCE: _____

DATE OF DEATH: _____

CAUSE OF DEATH: _____

PLACE OF DEATH: _____

DATE OF BURIAL: _____

PLACE OF BURIAL: _____

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

Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, 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.