MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-041348
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1070
2 1070
3
4 6
5 0
6
7 0
8 2
9 776X
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12 2-0
13 2-0

Registration District No. 354 Primary Registration District No. 4579 Registrar's No. 22

FILED OCT 16 1962

1. PLACE OF DEATH
a. COUNTY: Texas
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Cabool
Length of stay in 1b: 5 hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cabool Clinic
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Texas
c. CITY OR TOWN: none
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Joe Middle: Allen Last: Weatherman
4. DATE OF DEATH: Month Day Year: 9.25/62
5. SEX: m
6. COLOR OR RACE: W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/25/62
9. AGE (last birthday): 5 hrs.
IF UNDER 1 YEAR: Months Days Hours 5 Min. 30
IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Cabool, Mo.
12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: Betty Carolyn Weatherman
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Woodrow Weatherman, Mt. Grove, Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 9/25/62, to 9/25/62 and last saw ~~her~~ him alive on 9/25/62
Death occurred at 6:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James A Hasek (Degree or title) MD
22b. ADDRESS: Cabool, Mo.
22c. DATE SIGNED: 9/28/62

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 9/27/62
23c. NAME OF CEMETERY OR CREMATORY: Stubbs Cemetery
23d. LOCATION (City, town, or county) (State): Texas County, Mo.

24. FUNERAL DIRECTOR ADDRESS: Elliott-Gentry Funeral Home, Cabool, Mo.
25. DATE RECD. BY LOCAL REG.: 10-6-62
26. REGISTRAR'S SIGNATURE: Gaynell Cunningham

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

No embalming

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_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.