

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-041743

STATE FILE NUMBER

042

1000

1294

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 26 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

R.O. Craig, M.D. MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph			Length of stay in 1b 15 days		c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hosp.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Hannibal, Mo.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HATTIE Middle TURNER Last WHALEY			4. DATE OF DEATH Month November Day 14 Year 1962										
5. SEX female		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/27/1875		9. AGE (last birthday) 87		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) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Hannibal, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME John M. Turner				13b. MOTHER'S MAIDEN NAME unknown Shimer				14. NAME OF HUSBAND OR WIFE Volney H. _____					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT V. H. Whaley, #4 Crestview Village Address St. Joseph, 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) Cedene carcinoma of the Rectum										INTERVAL BETWEEN ONSET AND DEATH 3 mo			
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) Generalized arteriosclerosis										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 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 10/30/62 , to 11/14/62 and last saw her/him alive on 11/13/62				Death occurred at 7:20 a. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE R.O. Craig (Degree or title) MD						22b. ADDRESS 215 Kirkpatrick Bldg		22c. DATE SIGNED 11/15/62					
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 11/14/1962		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Hannibal		23e. STATE Missouri					
24. FUNERAL DIRECTOR Newton Bacon				ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Nov. 20, 1962		26. REGISTRAR'S SIGNATURE Wm. Clark Goodell					

NOV 30 1962

Permit issued 11/19/62

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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph 2000

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.