

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-041975

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 70 Primary Registration District No. _____ Registrar's No. _____

FILED DEC 3 1962

VS 300 Rev. 4/59	DATE AMENDED	1	0230
2		0230	
3			
4		1	
5		2	
6			
7		0	
8		2	
9		331X	
10			
11			
12		86-2	
13		1-1	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kahoka</u>		c. CITY OR TOWN <u>Kahoka</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunn Nursing Home</u>		d. STREET ADDRESS <u>250 W. Clark</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Maude</u> Last <u>Feldman</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1874</u>
9. AGE (last birthday) <u>88</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>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Memphis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>J. Y. McClenock</u>	
13b. MOTHER'S MAIDEN NAME <u>Helen Campbell</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Feldman</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>Harry Kearns, Kahoka, 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>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</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 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>10-17-62</u> to <u>10-18-62</u> and last saw her alive on <u>10-18-62</u> Death occurred at <u>5</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>S.H. Channing D.O.</u> (Degree or title)		22b. ADDRESS <u>Kahoka Mo</u>	22c. DATE SIGNED <u>10-20-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-20-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kahoka City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kahoka, Missouri</u>
24. FUNERAL DIRECTOR <u>D. L. Shaffer, Kahoka, Missouri</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-2-62</u>	26. REGISTRAR'S SIGNATURE <u>J.R. Bridges</u> <u>By T. B. H.</u>

USE BLACK INK OR TYPEWRITER RIBBON

STATE 05071304

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 *D. Schaffer*

Licensed Embalmer No. 5063

P. O. Address: Wichita, 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.