

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-041997

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 116

FILED NOV 16 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 6001
2 6001
3 2
4 1
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7 0
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9 4214
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12 2-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>204 Carron</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Angie Orilla Hightower</u>			4. DATE OF DEATH Month Day Year <u>November 6, 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>Aug. 2, 1878</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days 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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Caldwell Co, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Crouse</u>	
13b. MOTHER'S MAIDEN NAME <u>Simeon Hightower</u>		14. NAME OF HUSBAND OR WIFE <u>Iva Whelchel, Excelsior Springs, Mo</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 Address <u>Iva Whelchel, Excelsior Springs, 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 Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> DUE TO (b) <u>Arteriosclerotic valvular heart dis.</u> <u>years</u> DUE TO (c) <u>Arteriosclerosis</u> <u>years</u> 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 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>Dec. 1953</u> to <u>Nov. 6-62</u> and last saw her ^{her} alive on <u>6 Nov. 62</u> Death occurred at <u>9:25 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>		22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>11-8-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/10/ 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old New Garden</u>	23d. LOCATION (City, town, or county) (State) <u>Rural Excelsior Springs, Mo</u>
24. FUNERAL DIRECTOR <u>Richard Neal Home Inc. Excelsior Springs, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-8-62</u>	26. REGISTRAR'S SIGNATURE <u>Barlene Hutchings</u>

Permit received 11-8-62 - B.H.

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 Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Chelios Springs, 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.