

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-042116

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 93 Primary Registration District No. _____ Registrar's No. 62-70

FILED NOV 26 1962

VS 300
Rev. 4/59

6290

30290

3

4 1

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94200

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12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Center TWP</u> Length of stay in 1b <u>vrs</u>		c. CITY OR TOWN <u>Greenfield Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4mi East of Greenfield Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>4mi east</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Jane</u> Last <u>Scott</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>16</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>Dec 9 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE (last birthday) <u>95</u>
13a. FATHER'S NAME <u>Gipson Stockton</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Patterson</u>	14. NAME OF HUSBAND OR WIFE <u>Albert Scott</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>	
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>Arteriosclerotic Heart Disease</u>		17. INFORMANT <u>Archie W. Scott Greenfield Mo. rt.</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 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 <u>Greenfield Mo</u> COUNTY _____ STATE _____	
21. I attended the deceased from <u>10/27/62</u> to <u>11/16/62</u> and last saw her alive on <u>11/7/62</u> . Death occurred at <u>2:30p</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Lee A. McNeel, Jr. M.D.</u>		22b. ADDRESS <u>Greenfield Mo</u>	22c. DATE SIGNED <u>11/18/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 18 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>	23d. LOCATION (City, town, or county) (State) <u>Greenfield Mo.</u>
24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>11/23/1962</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>

USE BLACK INK

OR TYPEWRITER RIBBON

Lee A. McNeel, Jr., M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Shenfield Ave

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.