

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-042325

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 214 STATE FILE NUMBER

FILED NOV 26 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>GRUNDY</u>	a. STATE <u>MO</u>	b. COUNTY <u>GRUNDY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRENTON</u>	Length of stay in 1b <u>2 DAYS</u>	c. CITY OR TOWN <u>SPICKARD</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>1513 Chestnut WHITEFIELD NURSING HOME</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>IDA</u>	Middle	Last <u>BACON</u>	4. DATE OF DEATH	Month <u>NOV</u>	Day <u>19</u>	Year <u>1962</u>
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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>4-5-1874</u>	9. AGE (last birthday) <u>88-7-14</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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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	11. BIRTHPLACE (City and state or country) <u>MERCER CO. MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>ABRAHAM COX</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH JANE COON</u>	14. NAME OF HUSBAND OR WIFE <u>ALLEN BACON</u>
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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.	17. INFORMANT <u>MARSHALL BACON</u>	Address <u>Spickard Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
IMMEDIATE CAUSE (a)	<u>Cocci Culture Cocci</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Arteriosclerosis also Arteritis & Phlebitis</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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 1940 to Nov 1962 and last saw her/him alive on Nov 1962
Death occurred at 8:55 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. J. ...</u>	(Degree or title)	22b. ADDRESS <u>1 ...</u>	22c. DATE SIGNED <u>11/26/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-21-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u>	23d. LOCATION (City, town, or county) <u>SPICKARD MO.</u>
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24. FUNERAL DIRECTOR <u>WISE FUNERAL HOME</u>	ADDRESS <u>Spickard MO</u>	25. DATE RECD. BY LOCAL REG. <u>11-21-62</u>	26. REGISTRAR'S SIGNATURE <u>J. ...</u>
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard 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.