

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043272

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. _____ Registrar's No. 205

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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20530

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>LACADE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>LACADE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>UNION TWP</u>		Length of stay in 1b <u>8 YRS</u>	c. CITY OR TOWN <u>CONWAY MO RI</u>
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION <u>1 MI. S. CONWAY</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 MI SOUTH</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARA N PRESENELL</u>			4. DATE OF DEATH Month Day Year <u>NOV 15 1962</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1891</u>
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 _____	11. BIRTHPLACE (City and state or country) <u>IOWA</u>
13a. FATHER'S NAME <u>DAN KING</u>		13b. MOTHER'S MAIDEN NAME <u>MINERVA HOPKINS</u>	14. NAME OF HUSBAND OR WIFE <u>GEORGE OTTUMWA IOWA.</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. _____	17. INFORMANT <u>THERO. KING OTTUMWA IOWA.</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>CORONARY OCCLUSION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CORONARY ARTERY DISEASE</u>			<u>10 YRS.</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC CONGESTIVE HEART FAILURE</u>			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>6-15-60</u> to <u>11-15-62</u> and last saw <u>9</u> alive on <u>7-11-62</u> Death occurred at <u>6:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. J. Barcia, M.D.</u>		22b. ADDRESS <u>Marshfield, Mo.</u>	22c. DATE SIGNED <u>11-17-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-17-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BRACELAND</u>	23d. LOCATION (City, town, or county) (State) <u>LACADE CO MO</u>
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-1962</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Day</u>

USE BLACK INK OR TYPEWRITER RIBBON

JUL 28 1966

Permit not issued - H&P

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: George Stapp

Licensed Embalmer No. 3161

P. O. Address Mr. George 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.