

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043415
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 182

FILED DEC 5 1962

VS 300
Rev. 4/59

1 2611
2 8090
3 2
4 1
5 1
6
7 1
8 0
9 9
10 8
11
12 1-2
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Flagler</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u>			Length of stay in lb <u>7 Days</u>		c. CITY OR TOWN <u>Flagler Beach</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>Samaritan Hosp.</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Flagler Beach</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Ann</u> Last <u>Tidwell</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>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>11/17/1937</u>		9. AGE (last birthday) <u>25</u>		IF UNDER 1 YEAR Months Days Hours Min.		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>—</u>		11. BIRTHPLACE (City and state or country) <u>Detroit, Michigan</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Max Porte</u>				13b. MOTHER'S MAIDEN NAME <u>Katherine Ardres</u>				14. NAME OF HUSBAND OR WIFE <u>Larry C. Tidwell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>				16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Larry C. Tidwell</u>		Address <u>Box 182</u> <u>Flagler Beach Fla.</u>					
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Incomplete INTESTINAL</u>													
DUE TO (c) <u>OBSTRUCTION</u>										<u>1WK</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 Month, Day, Year a.m. p.m.													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>26 Nov 1962</u> to <u>2 DEC 1962</u> and last saw her/him alive on <u>2 DEC 1962</u> Death occurred at <u>7:00 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>[Signature]</u>						22b. ADDRESS <u>Leonard, No -</u>			22c. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 6, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem.</u>			23d. LOCATION (City, town, or county) (State) <u>Korena Florida</u>						
24. FUNERAL DIRECTOR <u>Lester Hutton Macon, mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12/6/62</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

USE BLACK INK
OR
TYPEWRITER RIBBON

DEC 5 - 1962

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 Charles L. Helton

Licensed Embalmer No. 4527

P. O. Address Macon, 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.