

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043494
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 211 Primary Registration District No. 4324 Registrar's No. 73-62

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | |
|--|---|---|--|---|--|
| FILED NOV 27 1962 | | 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>Miller</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Tuscumbia</u> | | a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Humphreys Hospital</u> | | Length of stay in 1b <u>5</u> days | | c. CITY OR TOWN <u>Dixon</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>Rt. 3</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | |
| First <u>CHARYL</u> Middle <u>LORENE</u> Last <u>BUECHTER</u> | | Month <u>November</u> Day <u>22</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-17-1962</u> | 9. AGE (last birthday) <u>5</u> | IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Miller County, Mo. USA</u> | |
| 12. CITIZEN OF WHAT COUNTRY | | 13a. FATHER'S NAME <u>Wilferd Buechter</u> | | 13b. MOTHER'S MAIDEN NAME <u>Lou Kuenzly</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>None</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 <u>Wilfred Buechter</u> | | Address <u>Rt. 3, Dixon, Mo.</u> | | | |
| 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 | |
| IMMEDIATE CAUSE (a) <u>Toxemia</u> | | | | <u>from birth</u> | |
| DUE TO (b) <u>Erythroblastosis Foetalis</u> | | | | <u>from birth</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) | | | | 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 <u>1:15</u> a.m. p.m. | Month, Day, Year <u>11-17-62</u> to <u>11-22-62</u> | | and last saw her alive on <u>11-22-62</u> | | |
| 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>11-17-62</u> to <u>11-22-62</u> and last saw her alive on <u>11-22-62</u> Death occurred at <u>1:15</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Paul Howard D.</u> (Degree or title) | | | 22b. ADDRESS <u>Tuscumbia, Missouri</u> | | 22c. DATE SIGNED <u>11-24-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-23-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Anthony, Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Scrivner-Stevinson Iberia, Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>11-24-1962</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. D. E. Kallenbach</u> |

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 This body was not embalmed, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.