

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043729

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 142

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 12 1962

VS 300
Rev. 4/59

10850
20460

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ft Leonard Wood</u>		Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>Willow Springs</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>US Army Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>PO Box 303</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Otis</u> Last <u>Darnell</u>			4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1962</u>
5. SEX <u>Male</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>14 May 86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (last birthday) <u>76</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>Hannibal, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Deceased</u>		13b. MOTHER'S MAIDEN NAME <u>Deceased</u>	14. NAME OF HUSBAND OR WIFE <u>Bernice Darnell (deceased)</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>UNKNOWN</u>	17. INFORMANT <u>Paul A. Dobyns, PO Box 303, Springs, Mo</u> Address <u>Willow</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>Cardiac arrest</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			
DUE TO (c) <u>Pulmonary Emphysema</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 _____ 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>December 2, 1962</u> to <u>December 8, 1962</u> and last saw him alive on <u>December 8, 1962</u> Death occurred at <u>1:35</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William E. O'Brien, Capt, MC</u> (Degree or title)		22b. ADDRESS <u>US Army Hospital Fort Leonard Wood, Missouri</u>	22c. DATE SIGNED <u>8 Dec 62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-8-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NOT KNOWN</u>	23d. LOCATION (City, town, or county) (State) <u>Willow Springs MO</u>
24. FUNERAL DIRECTOR <u>MOSS-WILLIAMS Waynesville MO</u>		25. DATE RECD. BY LOCAL REG. <u>12-8-62</u>	26. REGISTRAR'S SIGNATURE <u>Conrad J. Anderson</u>

Mount Adair 12/18/62

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 Clarence Mose

Licensed Embalmer No. 4896

P. O. Address Waynesville, 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.