

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045678

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 355 Primary Registration District No. 6202 Registrar's No. 19

FILED DEC 3 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Texas		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Texas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Summersville (Rural)		c. CITY OR TOWN Summersville (Rural)	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home...		d. STREET ADDRESS (If outside, give location) Rural Route # 1	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Elsworth Starnes			4. DATE OF DEATH Month Day Year November 1 1962
5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1897
9. AGE (last birthday) 65		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Lebanon, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Thomas Starnes	
13b. MOTHER'S MAIDEN NAME Irene Jamison		14. NAME OF HUSBAND OR WIFE Clyola E. Starnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes	17. INFORMANT Mrs. Clyola Starnes Rt. 1. Smsville, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction old			INTERVAL BETWEEN ONSET AND DEATH 6 hrs
DUE TO (b) new			2 months
DUE TO (c) Carcinomatosis			8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Carcinoma of pancreas and liver			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"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 s.m. Month, Day, Year p.m.			
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 June 1962 to Nov 1 and last saw ^{her} him alive on Oct 29 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. Lawrence Hampton D.O.		22b. ADDRESS Summersville	
22c. DATE SIGNED Nov 25 1962			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 3, 1962	23c. NAME OF CEMETERY OR CREMATORY Arroll Cemetery	23d. LOCATION (City, town, or county) (State) Arroll, Missouri
24. FUNERAL DIRECTOR Duncan Funeral Home Mtn. View, Mo.		25. DATE RECD. BY LOCAL REG. 11-29-62	26. REGISTRAR'S SIGNATURE Juha Powell

To Doctor 9: A.M. 11/2/62

Rec'd from Dr. 9:30 A.M. 11/24/62

To Local Registrar 9:45 A.M. 11/24/62

Burial Permit Issued

DEC 4 - 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 D. Partain*

Licensed Embalmer No. 5107

P. O. Address *Mt. View, 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.