

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045845

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 27 Primary Registration District No. 5096 Registrar's No. 235

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 8 1963	
<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>Bates</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Butler</u> Length of stay in lb <u>5 weeks</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pine Tree Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>Bates</u></p> <p>c. CITY OR TOWN <u>Butler</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p><b>3. NAME OF DECEASED</b> (Type or print) First <u>Austin</u> Middle <u>Eugene</u> Last <u>Camerer</u></p>	
<p><b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>29</u> Year <u>1962</u></p>	
<p><b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/></p>	
<p><b>8. DATE OF BIRTH</b> <u>11-17-1869</u> <b>9. AGE (last birthday)</b> <u>93</u></p>	
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Farming</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u> <b>11. BIRTHPLACE</b> (City and state or country) <u>Illinois</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u></p>	
<p><b>13a. FATHER'S NAME</b> <u>James K. Camerer</u> <b>13b. MOTHER'S MAIDEN NAME</b> <u>Theophila E. Troskaski</u> <b>14. NAME OF HUSBAND OR WIFE</b> <u>deceased</u></p>	
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No or unknown) (If yes, give war or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Mrs. Claire Dalrymple Granby, Mo.</u> Address</p>	
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Generalized Broncho-Pneumonia</u></p> <p style="text-align: center;">DUE TO (b) <u>Generalized Arterio-Sclerosis with</u></p> <p style="text-align: center;">DUE TO (c) <u>Cerebral Hemorrhage</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>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</p>	
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p><b>20c. TIME OF INJURY</b> Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.</p>	
<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> <b>20f. CITY, TOWN, OR LOCATION</b> <u>Butler, Mo.</u> COUNTY <u>Bates</u> STATE <u>Missouri</u></p>	
<p><b>21. I attended the deceased from</b> <u>Nov. 2, 1962</u> <b>to</b> <u>Dec. 29, 1962</u> <b>and last saw her/him alive on</b> <u>Dec. 20, 1962</u> <b>Death occurred at</b> <u>10 A. M.</u> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b></p>	
<p><b>22a. SIGNATURE</b> <u>Dorcas W. Luter</u> (Degree or title) <u>MD</u> <b>22b. ADDRESS</b> <u>Butler, Mo.</u> <b>22c. DATE SIGNED</b> <u>12-29-62</u></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>12-31-1962</u> <b>23b. DATE</b> <u>Greenwood Cemetery</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenwood Cemetery</u> <b>23d. LOCATION</b> (City, town, or county) (State) <u>Granby, Missouri</u></p>	
<p><b>24. FUNERAL DIRECTOR</b> <u>Shewmake Funeral Home Granby, Mo.</u> <b>ADDRESS</b> <u>12-31-62</u> <b>25. DATE RECD. BY LOCAL REG.</b> <u>Norman Wilson</u> <b>26. REGISTRAR'S SIGNATURE</b></p>	

VS 300 Rev. 4/59  
6071  
200701  
3  
4 0  
5 2  
6  
7 1  
8 2  
9 331X  
10  
11  
12 86-0  
13 1-0

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
SHOULD READ  
ITEM NO.  
BY AFFIDAVIT OF

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

**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 Paul D. Kimbark

Licensed Embalmer No. 4576

P. O. Address Cassville, 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.