

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-045098
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1227

FILED JAN 7 1963

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Rev. 4/59

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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 BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DOUGLAS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 3 DAYS	c. CITY OR TOWN AVA Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) GENERAL DELIVERY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRANK Middle WISE Last WISE			4. DATE OF DEATH Month DECEMBER Day 22 Year 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-24-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL	9. AGE (last birthday) 74 YEARS IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) FORT SMITH, ARKANSAS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JAMES A. WISE		13b. MOTHER'S MAIDEN NAME SALLY FRY	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. NONE	17. INFORMANT VA HOSPITAL RECORDS, POPLAR BLUFF, MO. Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CORONARY ARTERIOSCLEROTIC HEART DISEASE			UNKNOWN
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) DIABETES MELLITUS			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 AVA, MISSOURI COUNTY _____ STATE _____
21. Attended the deceased from DECEMBER 19, 1962 to DECEMBER 22, 1962 Death occurred at 10:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert S. Cohen</i> ROBERT S. COHEN M.D., CHIEF MED. SER.		22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 12-28-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 26, 62	23c. NAME OF CEMETERY OR CREMATORY Fannon	23d. LOCATION (City, town, or county) (State) Ava, Missouri
24. FUNERAL DIRECTOR Clinkingbeard Funeral Home, Ava, Mo.		25. DATE RECD. BY LOCAL REG. 1/2/1963	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>

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 _____

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.