

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-046725

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 4234 Registrar's No. 7

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 15 1963

1. PLACE OF DEATH a. COUNTY Iron		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Washington	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ironton		Length of stay in 1b 1 day	c. CITY OR TOWN Caledonia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's		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 Middle Last CAROL ANNE SADLER			4. DATE OF DEATH Month Day Year December 28, 1962		
5. SEX female	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 Dec. 27, 1962	9. AGE (last birthday) 1	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Ironton, Mo.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Lyman Sadler		13b. MOTHER'S MAIDEN NAME Mary Shelton		14. NAME OF HUSBAND OR WIFE Lyman Sadler	
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. none	17. INFORMANT Address Lyman Sadler, Caledonia, 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) Congenital Atelectasis Interval between onset and death 1 day	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) premature birth (32 weeks gestation)		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 12-27-62 to 12-28-62 and last saw her ^{her} _{alive} on 12-28-62
Death occurred at 11:00 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. E. Jarland</i> (degree or title)	22b. ADDRESS Ironton, Missouri	22c. DATE SIGNED 1-4-63
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12/30/1962	23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	23d. LOCATION (City, town, or county) (State) Caledonia, Missouri
--	--------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS White Funeral Home, Ironton, Mo. <i>Sgt. H. White</i>	25. DATE RECD. BY LOCAL REG. 1-4-63	26. REGISTRAR'S SIGNATURE <i>Miss Aris Jones</i>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
10470
2100~
3
4 1
5 0
6
7 0
8 2
9762.5
10
11
12 1-0
13 1-0

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 Amel White _____

Licensed Embalmer No. 3012

P. O. Address Ironton, 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.