

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-047647

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

200
 Registration District No. **200** Primary Registration District No. **3041** Registrar's No. **198**
FILED DEC 21 1962

VS 300
Rev. 4/59

2611
30610

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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 Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Macon		Length of stay in 1b		c. CITY OR TOWN Callao	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Samaritan Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle MORROW Last			4. DATE OF DEATH Month Nov. Day 17 Year 1962		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/5/1883	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Audrian Co. Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Green Patrick		13b. MOTHER'S MAIDEN NAME Anna Rector	
14. NAME OF HUSBAND OR WIFE Pearl Morrow		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.	
17. INFORMANT Pearl Morrow		Address Callao, 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) Acute Circulatory Failure					INTERVAL BETWEEN ONSET AND DEATH 10 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure					4 days
DUE TO (c) Atherosclerosis					years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Vascular Accident 2 years ago				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Nov 8, 1962 to Nov 17, 1962 and last saw her alive on Nov 16, 1962 Death occurred at 7:55 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Dr. Buffingbury DO</i>			22b. ADDRESS Bevier Missouri		22c. DATE SIGNED 11/20/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-19-1962	23c. NAME OF CEMETERY OR CREMATORY Locust Grove		23d. LOCATION (City, town, or county) (State) Callao Missouri
24. FUNERAL DIRECTOR Edwards Funeral Home			25. DATE RECD. BY LOCAL REG. 12/15/62		26. REGISTRAR'S SIGNATURE <i>Cuthbert M. Healy</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 Philip E. Bram

Licensed Embalmer No. 5182

P. O. Address Macon 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.