

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047853

STATE FILE NUMBER

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 233

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED JAN 2 1963</b>	
1. PLACE OF DEATH a. COUNTY <u>Bemiss</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wayhi</u> Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Bemiss</u> c. CITY OR TOWN <u>Steele</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Rt 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter B. Michie</u> 4. DATE OF DEATH Month Day Year <u>12-13-62</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-94</u> 9. AGE (last birthday) <u>78</u> IF UNDER 1 YEAR: Months <u>5</u> Days <u>26</u> IF UNDER 24 HR: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Geo. Merchant</u> 11. BIRTHPLACE (City and state or country) <u>Louis Post Ky</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Benjamin Michie</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	13b. MOTHER'S MAIDEN NAME <u>Sallie White</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Mrs. Alona Michie</u> Address <u>Steele Rt 3</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obstructive Pulmonary Disease</u> 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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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 checked="" 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 <u>Dec 1, 1962</u> to <u>Dec 13, 1962</u> and last saw him alive on <u>Dec 13, 1962</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>W. Davis</u> (Degree or title) _____ 22b. ADDRESS <u>Carthage Mo</u> 22c. DATE SIGNED <u>12/14/62</u>	23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>12-16-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Maple</u> 23d. LOCATION (City, town, or county) (State) <u>Carthage Mo</u>
24. FUNERAL DIRECTOR <u>German Funeral Home</u> ADDRESS <u>Steele Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-26-62</u> 26. REGISTRAR'S SIGNATURE <u>Charlotte E. Sloan</u>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED  
VS 300 Rev. 4/59  
0781  
0780  
3  
4 0  
5 1  
6  
7 1  
8 2  
9 420.1  
10  
11  
12 1-0  
13 1-0

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

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**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 John F. McClure

Licensed Embalmer No. 5704

P. O. Address St. Louis, Missouri

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.