

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-047968

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 282 Primary Registration District No. \_\_\_\_\_ Registrar's No. 138

FILED JAN 2 1963

VS 300  
Rev. 4/59

10846  
30840

3

4 1

5 2

6

7 1

8 2

97954

10

11

12 96-8

13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |   |
| a. COUNTY <u>Polk</u>   |   | a. STATE <u>Mo</u>  | b. COUNTY <u>Polk</u>   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North West Marion</u>  |   | c. CITY OR TOWN <u>Bolivar, Mo</u>  |   |
| Length of stay in lb <u>27 Years</u>  |   | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>   |   | d. STREET ADDRESS (If outside, give location) <u>Rt 2</u>   |   |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)   |   |   | 4. DATE OF DEATH  |
| First <u>Lora</u>   | Middle <u>Anna</u>  | Last <u>Tobin</u>   | Month <u>December</u> Day <u>26</u> Year <u>1962</u>                                      |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 18, 1887</u>  |
| 9. AGE (last birthday) <u>75</u>  |   | IF UNDER 1 YEAR   | IF UNDER 24 HR  |
|   |   | Months  | Days  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   | 11. BIRTHPLACE (City and state or country) <u>St. John, Kan</u>                           |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u>  |   | 13a. FATHER'S NAME <u>John Rice</u>   |   |
| 13b. MOTHER'S MAIDEN NAME <u>Kate Ungrey</u>  |   | 14. NAME OF HUSBAND OR WIFE <u>Clyde Tobin Deceased</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>None</u>   |   |
| 17. INFORMANT <u>Duane Tobin Rt 2 Bolivar, Mo</u>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <u>Presumed to be natural causes</u>  |   |   |   |
| 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)                             |   |   | 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 _____ to _____ and last saw her/him _____ on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| Death occurred at <u>4:30 P.</u>  |   |   |   |
| 22a. SIGNATURE <u>Ralph Gordon</u> (Degree or title) <u>Registrar</u>   |   | 22b. ADDRESS <u>Bolivar Mo.</u>   |   |
| 22c. DATE SIGNED <u>12-27-62</u>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE <u>12/28/62</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Barren Creek</u>  | 23d. LOCATION (City, town, or county) <u>North West Bolivar, Mo</u>                       |
| 24. FUNERAL DIRECTOR <u>Paul D. Butler</u> ADDRESS <u>Bolivar, Mo</u>   |   | 25. DATE RECD. BY LOCAL REG. <u>Dec. 27 - 1962</u>  | 26. REGISTRAR'S SIGNATURE <u>Ralph Gordon</u>   |

JAN 7 1963

**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. Butler

Licensed Embalmer No. 4471

P. O. Address Bolivar, 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.