

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049213

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 280

1. PLACE OF DEATH
 a. COUNTY Scott
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston Length of stay in 1b 1 Day
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital Inside Limits Yes No
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri COUNTY Mississippi
 c. CITY OR TOWN Charleston Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 1200 Charleston Ave Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Gladys Treacy Council
4. DATE OF DEATH Month Day Year December 27, 1962
5. SEX Female **6. COLOR OR RACE** White **7. Married** Never Married Widowed Divorced
8. DATE OF BIRTH 10/30/99 **9. AGE (last birthday)** 63 IF UNDER 1 YEAR IF UNDER 24 HR. 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** Home **11. BIRTHPLACE** (City and state or country) Columbus, Ky. **12. CITIZEN OF WHAT COUNTRY** U.S.A.
13a. FATHER'S NAME N.C. Harwell **13b. MOTHER'S MAIDEN NAME** Katherine Harwell **14. NAME OF HUSBAND OR WIFE** Forest Council
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.** Unknown **17. INFORMANT** Forest Council, Charleston, 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) Ventricular Fibrillation INTERVAL BETWEEN ONSET AND DEATH 1 day
 DUE TO (b) Angina Pectoris 6 mo
 DUE TO (c) Hypertension 8 yrs
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT **SUICIDE** **HOMICIDE**
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 NOT WHILE AT WORK
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 5-19-50 to 12-27-62 and last saw ^{her} him alive on 12-27-62
 Death occurred at 9:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) [Signature] **22b. ADDRESS** 510 South Main St Charleston, Mo. **22c. DATE SIGNED** 12-29-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE** 12/30/62 **23c. NAME OF CEMETERY OR CREMATORY** Odd Fellows Cemetery **23d. LOCATION** (City, town, or county) (State) Charleston, Missouri
24. FUNERAL DIRECTOR ADDRESS McMikle, Charleston, Missouri **25. DATE RECD. BY LOCAL REG.** Dec 31-1962 **26. REGISTRAR'S SIGNATURE** Jeanette Waldman

VS 300 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

Permit received Dec 27-1962

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 Bruce R. Austin
Licensed Embalmer No. 5149

P. O. Address East Prairie, 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.