

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049231

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 323 Primary Registration District No. 3074 Registrar's No. 275

FILED DEC 26 1962

VS 300
Rev. 4/59

DATE AMENDED

1 1007
2 0720

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4 1

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9 1750

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12 1-0

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Length of stay in lb <u>7 days</u>	c. CITY OR TOWN <u>Matthews</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>Mo. Delta Community</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>MATIE</u> Last <u>Taber</u>		4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</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>MAR 7, 1914</u>
9. AGE (last birthday) <u>48</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>10</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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></u>	11. BIRTHPLACE (City and state or country) <u>MATTHEWS, MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Charles Lancaster</u>	
13b. MOTHER'S MAIDEN NAME <u>Candelina Coult</u>		14. NAME OF HUSBAND OR WIFE <u>Larry B. Taber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Larry B. Taber - Matthews, Mo</u> 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) <u>Carcinomatosis</u> DUE TO (b) <u>Adenocarcinoma of ovary</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></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 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.) <u></u>	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year, <u></u>			
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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
21. I attended the deceased from <u>9-15-62</u> to <u>12-17-62</u> and last saw her/him alive on <u>12-17-62</u> Death occurred at <u>6:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John Sargent M.D.</u>		22b. ADDRESS <u>Sikeston Mo</u>	22c. DATE SIGNED <u>12-17-62</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Dec. 19, 1962</u>		23b. DATE <u></u>	23c. NAME OF CEMETERY OR CREMATORY <u>Matthews Cem. Matthews, Mo.</u>
23d. LOCATION (City, town, or county) <u></u>		23e. (State) <u></u>	
24. FUNERAL DIRECTOR <u>Sikeston Funeral Home</u> <u>Sikeston, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 21-62</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>

USE BLACK INK OR TYPEWRITER RIBBON

JAN 4 1963

Permit received Dec 17 - 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 Raymond L. Duffie

Licensed Embalmer No. 4798

P. O. Address Bernie, 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.