

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049337

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 182

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1086
2930

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Clair</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Length of stay in lb <u>1 y 11 mo 24 d</u>	c. CITY OR TOWN <u>Appleton City</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 3</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>unk</u>
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Thomas</u> Last <u>Page</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-19-83</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John M. Page</u>	
13b. MOTHER'S MAIDEN NAME <u>Emma V Croy</u>		14. NAME OF HUSBAND OR WIFE <u>Divorced</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT <u>Parents</u> Address <u>State Hosp. # 3 Nevada Mo</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>Branchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10da</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) <u>Chronic Brain Syndrome assoc. to Senile Brain 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 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.	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 viewed the remains at <u>12:15 pm 12-28-62</u> and last saw her <u>him</u> alive on _____ Death occurred at <u>11:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Joe D Combs</u> (Degree or title)		22b. ADDRESS <u>Nevada Mo</u>	22c. DATE SIGNED <u>12-28-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (Stamp)
<u>Remove to Burial</u>	<u>Dec 30-62</u>	<u>Mt Zion Cemetery</u>	<u>Approx. 15mi N.E. El Dorado Springs Missouri</u>
24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG	26. REGISTRAR'S SIGNATURE
<u>Melvin L. JANSSENS</u>	<u>El Dorado Springs</u>	<u>Dec 29-1962</u>	<u>Anna B. Ferry</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

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 *Melvin L. Jensen*
Licensed Embalmer No. 4529

P. O. Address *El Dorado Spgs.*

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.