

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

FILED APR 18 1963  
 Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 54 STATE FILE NUMBER 62-049696

DO NOT WRITE ON THIS STUB

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>DELAWARE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pike</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Louisiana</b>		Length of stay in 1b <b>52 days</b>	c. CITY OR TOWN <b>Clarksville</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pike County Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.F.D. One</b>		
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Marie</b> Last <b>Ward</b>			4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/1/1923</b>	9. AGE (last birthday) <b>39</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Louisiana, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Thomas R. Harris</b>			13b. MOTHER'S MAIDEN NAME <b>Helen J. Sladek</b>		14. NAME OF HUSBAND OR WIFE <b>Shelby L. Ward</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address <b>Shelby L. Ward, Clarksville, Missouri</b>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Cervix</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Two years</b>	
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 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 <b>1960</b> to <b>Aug 13, 1962</b> and last saw her alive on <b>Aug 13, 1962</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>W. Joe Martin, M.D.</b>			22b. ADDRESS <b>Louisiana, Mo.</b>		22c. DATE SIGNED <b>4-5-63</b>	
23a. BURIAL, CREATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 15, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Louisiana, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Geo. M. Collier, Louisiana, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>4-5-63</b>	26. REGISTRAR'S SIGNATURE <b>Bernice Collier</b>		

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.