

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000309  
STATE FILE NUMBER

38 Primary Registration District No. 3006 Registrar's No. 4

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

16109  
2690

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95210X

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED JAN 7 1963</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>BOONE</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Columbia</b>		a. STATE <b>Mo.</b> b. COUNTY <b>MONROE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Columbia</b>		Length of stay in 1b <b>6 wks.</b>		c. CITY OR TOWN <b>MADISON</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>University of Mo. Medical</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RFD 1</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX	
First <b>ORA</b> Middle <b>E.</b> Last <b>Willingham</b>		Month <b>1</b> Day <b>3</b> Year <b>63</b>		6. COLOR OR RACE <b>W</b>	
5. SEX <b>F</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>4-15-03</b>	
6. COLOR OR RACE <b>W</b>		9. AGE (last birthday) <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>MADISON, Mo.</b>	
13a. FATHER'S NAME <b>Thomas Frederick Brown</b>		13b. MOTHER'S MAIDEN NAME <b>Annie Hickerson</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Medical Records Columbia Mo</b>	
18. CAUSE OF DEATH (Enter only one cause of death)		18. CAUSE OF DEATH (Enter only one cause of death)		INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>	
PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a) <b>COR PULMONALE</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>BRONCHIECTASIS AND</b>			
		DUE TO (c) <b>CHRONIC LUNG DISEASE</b>			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
PNEUMONIA					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 attended the deceased from <b>12/15/62</b> to <b>1/3/63</b> and last saw her alive on <b>1/3/63</b>		21. I attended the deceased from <b>12/15/62</b> to <b>1/3/63</b> and last saw him alive on <b>1/3/63</b>		Death occurred at <b>12:25 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Richard R. Jole MD</b> (Degree or title)		22b. ADDRESS <b>206 Ruby Lane</b>		22c. DATE SIGNED <b>1/3/63</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-5-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia Cem</b>	
<b>Burial</b>				23d. LOCATION (City, town, or county) <b>Audrain Co. Mo</b> (State)	
24. FUNERAL DIRECTOR <b>Cater Funeral Home Moberly Mo</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>Jan 3 1963</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>	

(Licensed Embalmer's Statement on Reverse Side)

MISSOURI DEPARTMENT OF HEALTH

**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 Jerry R. Cater

Licensed Embalmer No. 4906

P. O. Address Moberly, 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.