

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000313

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 116

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 6 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 9 years	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2820 Faraon

3. NAME OF DECEASED (Type or print) First MELVINA Middle MAUD Last ALLEN			4. DATE OF DEATH Month January Day 30, Year 1963	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1874	9. AGE (last birthday) 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Maysville, Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE C. D. Allen

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. [redacted]	17. INFORMANT Mrs. Kenneth Lawrence, 2820 Faraon, St. Joseph
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. U. A			INTERVAL BETWEEN ONSET AND DEATH 12 hrs
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 (e) A.S.H.D.			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	
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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 _____ s.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 1952 to TIME of death and last saw her alive on JAN 15-63
Death occurred at 10:30 p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title)	22b. ADDRESS [Address]	22c. DATE SIGNED 2-1-63
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23a. BURIAL CREMATION, REMOVAL (Specify) burial	23b. DATE 2/2/1963	23c. NAME OF CEMETERY OR CREMATORY High Ridge Cemetery	23d. LOCATION (City, town, or county) Stanberry Missouri
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24. FUNERAL DIRECTOR [Signature] ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Feb. 4, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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VS 300 Rev. 4/59

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25117

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

M.F. Grimes, M.D. MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 2/1/63

2/1/63
2/1/63

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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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St. Joseph, 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.