

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004801

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 2074 Registrar's No. 40

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 11 1963

VS 300
Rev. 4/59

1 1007
2 1007
3
4 1
5 2
6
7 1
8 0
9 4.500
10
11
12 90-0
13 2-0

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>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		Length of stay in 1b	c. CITY OR TOWN <u>SIKESTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>245 WATSON ST</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>245 WATSON ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>OPHELIA</u> Middle <u>KINDRED</u> Last <u>BISHOP</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>4</u> Year <u>1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1980</u>
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>KY</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>KINDRED</u>	
13b. MOTHER'S MAIDEN NAME <u>NANCY ELLEN POOLE</u>		14. NAME OF HUSBAND OR WIFE <u>J.R.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mr Jake Thomas - Sikeston Mo</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis with arteriosclerotic heart disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
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 checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 checked="" 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 <u>2-3-63</u> to <u>2-4-63</u> and last saw her ^{her} _{him} alive on <u>2-3-63</u> Death occurred at <u>6:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E.D. Urban M.D.</u>		22b. ADDRESS <u>Sikeston</u>	22c. DATE SIGNED <u>2-6-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-6-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES</u>	23d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>
24. FUNERAL DIRECTOR <u>Wald Funeral Home - Sikeston Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-8-1963</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldmark-L.</u>

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Seaton 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.