

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

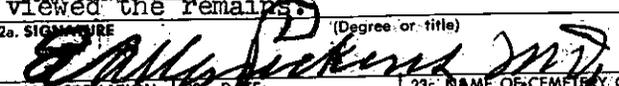
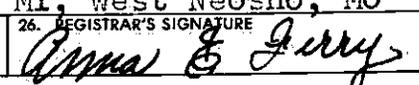
-63-004917

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 23

STATE FILE NUMBER

FILED FEB 1 1963

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Vernon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada, Missouri</u> Length of stay in 1b <u>10 mos</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"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u> c. CITY OR TOWN <u>Granby, Missouri</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> First Middle Last <u>Eva Viola Cummings</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>1 27 1963</u>				
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>10/3/1884</u>		<b>9. AGE (last birthday)</b> <u>78 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. IF UNDER 24 HR.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Indian Springs, Mo.</u>		
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>							
<b>13a. FATHER'S NAME</b> <u>James W. Phenix</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary Ann Rowley</u>		<b>14. NAME OF HUSBAND OR WIFE</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Hospital Records, State Hospital #3</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>yrs.</u> DUE TO (b) <u>General Arteriosclerosis</u> <u>yrs.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21.</b> attended the deceased from <u>3/26/62</u> to <u>1/27/63</u> and last saw her/him alive on <u>1/26/63</u> Death occurred at <u>3:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
I viewed the remains.				<b>22a. SIGNATURE</b> (Degree or title) 		<b>22b. ADDRESS</b>	
<b>22c. DATE SIGNED</b> <u>1/27/63</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>1-30-1963</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Thrasher Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>7 Mi. West Neosho, Mo</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Clark Funeral Home Neosho, Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>1-29-1963</u>		<b>26. REGISTRAR'S SIGNATURE</b> 		

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
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 MEDICAL CERTIFICATION  
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 USE BLACK INK OR TYPEWRITER RIBBON

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**STATEMENT BY LICENSED EMBALMER**

0-8P

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 *H. Wayne Brown*

Licensed Embalmer No. 5191

P. O. Address 637 Park St.

Providence, R.I.

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.