

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005197

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 170

FILED MAR 7 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SALINE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COLUMBIA		Length of stay in 1b 6 DAYS	c. CITY OR TOWN MARSHALL
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIVERSITY OF MISSOURI MEDICAL CENTER		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 776 W. BOYD
3. NAME OF DECEASED (Type or print) First LOLA Middle WHITE Last FINLEY		4. DATE OF DEATH Month MARCH Day 4 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-1-77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (last birthday) 85
13a. FATHER'S NAME ABE WHITE		11. BIRTHPLACE (City and state or country) SALINE CO. MO.	
13b. MOTHER'S MAIDEN NAME JULIA		12. CITIZEN OF WHAT COUNTRY UNITED STATES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		14. NAME OF HUSBAND OR WIFE Finley	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address UNIVERSITY OF MISSOURI MEDICAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Recent Fracture, Left Hip			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell at home, details unknown	
20c. TIME OF INJURY Hour Feb 24, 1963 a.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.) Home - Hospital		20f. CITY, TOWN, OR LOCATION Marshall	
21. I attended the deceased from Feb 26, 1963 to March 4, 1963 and last saw her alive on 9:20 PM, 3-4-63		22. ADDRESS Univ. Mo. Med. Center Columbia Mo	
22a. SIGNATURE (Deceased or title) George R. Sutton, M.D.		22c. DATE SIGNED Mar 4, 1963	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/8/63	23b. DATE 3/8/63	23c. NAME OF CEMETERY OR CREMATOR Swainson Cem	23d. LOCATION (City, town or county) (State) Marshall, Mo
24. FUNERAL DIRECTOR George R. Sutton, M.D.		25. DATE RECD. BY LOCAL REG. March 5, 1963	
26. REGISTRAR'S SIGNATURE Mrs R E Palmer			

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 *August Green*

Licensed Embalmer No. 4220

P. O. Address *Indian 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.