

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005250

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registered ³⁷ ~~FILED~~ **MAR 12 1963** Primary Registration District No. 4049 Registrar's No. 11

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300,
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. 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 Mo b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) Centralia		Length of stay in 1b 6 weeks	c. CITY OR TOWN Centralia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. HOSPITAL OR INSTITUTION Campbell Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 117 S. Hickman Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bessie Middle Maye Last Sutherland			4. DATE OF DEATH Month March Day 7 Year 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct 31, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaking	9. AGE (last birthday) 62 IF UNDER 1 YEAR: Months 4 Days 6 IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) Crocker, Iowa		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Calvin Jackson		13b. MOTHER'S MAIDEN NAME Lena Kurtz	14. NAME OF HUSBAND OR WIFE Warren J. Sutherland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)		16. SOCIAL SECURITY NO. 31	17. INFORMANT Address Warren J. Sutherland, Hallsville, Mo
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralysis agitans with cardiovascular accident and left hemiplegia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis and generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH several months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Pyelonephritis			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"/> 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 _____ a.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 2-15-63 to 3-7-63 and last saw her/him alive on 3-6-63 Death occurred at 4:35 p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <i>Robert L. Ward MD</i>		22b. ADDRESS Centralia, Missouri	22c. DATE SIGNED 3-8-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE March 10, '63	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope	23d. LOCATION (City, town, or county) (State) Madrid, Iowa
24. FUNERAL DIRECTOR ADDRESS <i>Geo. J. Meador Centralia, Missouri Mar. 8, 1963</i>		25. DATE RECD. BY LOCAL REG. Mar 8 1963	26. REGISTRAR'S SIGNATURE <i>Maud Mrs. Bride</i>

USE BLACK INK OR TYPEWRITER RIBBON

JUL 15 1966

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 Bill J. Meador

Licensed Embalmer No. 4876

P. O. Address Centerville, Missouri

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.

Permit issued. Mar. 8th. 1963 - 1965