

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005518

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 73

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1 0147
2 0140-

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4 1

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 4 1963

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in lb <u>10 Months</u>	c. CITY OR TOWN <u>Williamsburg</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Mem. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D. #1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>R.</u> Last <u>Helms</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</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>3/4/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (last birthday) <u>82</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (City and state or country) <u>Elkton, Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Rountree</u>		13b. MOTHER'S MAIDEN NAME <u>Unk</u>	14. NAME OF HUSBAND OR WIFE <u>James D. Helms</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT <u>Rosco R. Helms, Williamsburg, Mo</u> Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lungs - bronchopneumonia</u> DUE TO (b) <u>Emaciation</u> DUE TO (c) <u>Recto-Sigmoid - adenocarcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Heart, mitral valve - inactive rheumatic valvulitis</u>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>			
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>6:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Fred P. Handler MD</u> (Degree or title)		22b. ADDRESS <u>Jefferson City, Mo.</u>	22c. DATE SIGNED <u>2 Mar. 63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 5, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>unk</u>	23d. LOCATION (City, town, or county) (State) <u>Madrid Iowa</u>
24. FUNERAL DIRECTOR <u>Browning Funeral Home, Fulton Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>March 2-1963</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

STATE OF MISSOURI

1910

STATEMENT BY LICENSED EMBALMER

0-1

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 *A. R. Maxine*

Licensed Embalmer No. 4996
P. O. Address Fulton, 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.