

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005840

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **93**  
**FILED MAR 5 1963**

Primary Registration District No. \_\_\_\_\_ Registrar's No. **63-11**

STATE FILE NUMBER

VS 300  
Rev. 4/59

1 **0290**

2 **0060**

3 **2**

4 **1**

5 **1**

6

7 **0**

8 **2**

9 **53.0**

10

11

12 **1-0**

13 **1-0**

DATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Dade</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Barton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lockwood</b>		Length of stay in 1b <b>5 days</b>	c. CITY OR TOWN <b>Golden City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lockwood Mem. Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>None</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>MARIE</b> Last <b>DISNEY</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>25</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/6/1909</b>
9. AGE (last birthday) <b>53</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Dade Co., Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Thomas Mason Gehon</b>	
13b. MOTHER'S MAIDEN NAME <b>Cottew French</b>		14. NAME OF HUSBAND OR WIFE <b>Ray Disney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Ray Disney, Golden City, Mo.</b>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>metastatic disease of brain</b> DUE TO (c) <b>Adenocarcinoma of Cecum</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Metastatic disease to lungs.</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>Feb 20, 1963</b> to <b>Feb 25, 1963</b> and last saw her alive on <b>Feb 25, 1963</b> Death occurred at <b>9:30</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Harold A. Bauer, M.D.</b>		22b. ADDRESS <b>Lockwood, MO</b>	22c. DATE SIGNED <b>2-26-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/27/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Golden City, Mo.</b>
24. FUNERAL DIRECTOR <b>Phillips Funeral Home, Golden City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 1, 1963</b>	26. REGISTRAR'S SIGNATURE <b>J. C. Canada</b>

USE BLACK INK OR TYPEWRITER RIBBON

Harold A. Bauer, M.D.

Missouri State Board of Health

Golden City

2 days

looked

looked well. Post-

1918

WILLIAM

THOMAS

22

1918

1918

1918

1918

1918

1918

1918

1918

1918-1919

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 W. B. Rugh  
\_\_\_\_\_

Licensed Embalmer No. 3278

P.O. Address Golden City, 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.

MISSOURI STATE BOARD OF HEALTH