

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005966

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 129 Primary Registration District No. _____ Registrar's No. 16

FILED FEB 19 1963

VS 300 Rev. 4/59	DATE AMENDED	
10380		
21130		
3		
4 0		
5 2		
6		
7 1		
8 2		
9491X		
10	INSTEAD OF	
11		
1286-0		
13 1-0		
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS		
ITEM NO. SHOULD READ		
BY AFFIDAVIT OF		

1. PLACE OF DEATH a. COUNTY Gentry			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Worth		
b. CITY (If outside corporate limits, give TOWNSHIP only) Town Stanberry		Length of stay in 1b 4 1/2 months	c. CITY OR TOWN Grant City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Harmony Hill Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Grant City	
3. NAME OF DECEASED (Type or print) First John Middle Dallas Last Scadden			4. DATE OF DEATH Month January Day 14 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-16-1860	9. AGE (last birthday) 102	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) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (City and state or country) Meggs County, Ohio	12. CITIZEN OF WHAT COUNTRY U. S.
13a. FATHER'S NAME James Scadden		13b. MOTHER'S MAIDEN NAME Samantha Barrett		14. NAME OF HUSBAND OR WIFE Lucy Lavesta Scadden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address Mrs. Goldie McClellan - Grant City, Mo.		
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY)					INTERVAL BETWEEN ONSET AND DEATH 3 days
IMMEDIATE CAUSE (a) Broncho pneumonia, suspected					
DUE TO (b) undetermined					
DUE TO (c) _____					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) generally arteriosclerosis					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 9-6-62 to 1-14-63 and last saw ^{her} him alive on 1-14-63 Death occurred at 10:45 AM m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Arthur L. Carlin MD			22b. ADDRESS Stanberry, Missouri		22c. DATE SIGNED 1-19-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 16, 1963	23c. NAME OF CEMETERY OR CREMATORY Grant City Cemetery	23d. LOCATION (City, town, or county) (State) Grant City, Missouri		
24. FUNERAL DIRECTOR Bill A. Dunfee - Grant City, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. 2-13-'63	26. REGISTRAR'S SIGNATURE Mrs. L. W. Bare	

(Licensed Embalmer's Statement on Reverse Side)

Rec'd
2-13-63

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 A. Dunbar

Licensed Embalmer No. 4908

P. O. Address Spring 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.