

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007593

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 32

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0611

2 10202

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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

FILED MAR 12 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Macon</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon, Mo.</u> Length of stay in 1b <u>10 days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Samamitan Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>Shelby</u></p> <p>c. CITY OR TOWN <u>Clarence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Clarence, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Page Anthony Danner</u></p>	<p>4. DATE OF DEATH Month Day Year <u>Feb. 26, 1963</u></p>
<p>5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Dec. 12, 1867</u> 9. AGE (last birthday) <u>95</u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> 11. BIRTHPLACE (City and state or country) <u>Macon County</u></p>
<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	<p>13a. FATHER'S NAME <u>Jemimah Danner</u> 13b. MOTHER'S MAIDEN NAME <u>Martha Limbel</u> 14. NAME OF HUSBAND OR WIFE <u>Kate Danner</u></p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>	<p>17. INFORMANT Address <u>Nellie Perry Clarence, Mo.</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Condition Following Surgery for Strangulated Inguinal Hernia</u> <u>10 days</u></p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a)</p> <p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>
<p>21. I attended the deceased from <u>Feb. 16</u> to <u>Feb 26</u> and last saw her/him alive on <u>Feb 26, 1963</u>. Death occurred at <u>10 45</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>James E. Campbell MD</u></p>	<p>22b. ADDRESS <u>Macon Mo</u> 22c. DATE SIGNED <u>3/1/63</u></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>March 1, 1963</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Taber</u> 23d. LOCATION (City, town, or county) (State) <u>Atlanta, Mo.</u></p>
<p>24. FUNERAL DIRECTOR ADDRESS <u>Greening Clarence, Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>3/6/63</u> 26. REGISTRAR'S SIGNATURE <u>Cuth M. Neely</u></p>

USE BLACK INK OR TYPEWRITER RIBBON

EMBALING BOARD

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. 689
working under my personal supervision.

Student William H. Shering
Signature of Student Embalmer

Signed Charles V. Shering

Licensed Embalmer No. 4625

P. O. Address Claremont, Md

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.