

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007711

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 2463 Primary Registration District No. 5786 Registrar's No. 21

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300  
Rev. 4/59

1 0670  
2 0670  
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7 1  
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12 290-0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>		
b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN <b>Charleston</b>		Length of stay in 1b <b>30 yrs.</b>	c. CITY OR TOWN <b>Charleston</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 3</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>Route 3</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Tom Wright</b>			4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/7/98</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City, and state or country) <b>Huntsville, Ala.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Charlie Wright</b>		13b. MOTHER'S MAIDEN NAME <b>Sakie (Unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>Hattie Ann Wright</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 Address <b>Johnnie Mae Davis, R. 3, Charleston, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gangrene of left foot</b> DUE TO (b) <b>Peripheral vascular disease</b> DUE TO (c) <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).				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 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>July 6 1962</b> to <b>2/14/63</b> and last saw him alive on <b>2/12/63</b> Death occurred at <b>7:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>E. Charles Falving M.D.</b>			22b. ADDRESS <b>Charleston Mo</b>		22c. DATE SIGNED (State) <b>2/15/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/17/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) <b>Charleston, Missouri</b>	
24. FUNERAL DIRECTOR <b>L. R. Sparks</b> ADDRESS <b>Charleston, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>2-17-63</b>		26. REGISTRAR'S SIGNATURE <b>Dorothy B. Hathorn</b>	

FEB 27 1963

Permit received  
2-17-63  
JK

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 James A Carter  
Licensed Embalmer No. 4481

P. O. Address C. Vills, 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.

0-09