

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-007822

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. _____ STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

FILED MAR 11 1963

VS 300 Rev. 4/59	DATE AMENDED		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS		DOCUMENT		INSTEAD OF		MEDICAL CERTIFICATION		BY AFFIDAVIT OF		SHOULD READ		ITEM NO.							
0745																						
0740																						
3																						
4 0																						
5 1																						
6																						
7 0																						
8 2																						
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1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Length of stay in 1b <u>20 days</u>		c. CITY OR TOWN <u>Parnell</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>none</u>			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SCOTT STONE</u>				4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>63</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10/24/84</u>	
9. AGE (last birthday) <u>78</u>		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) <u>Employee-Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>CGW Railway</u>		11. BIRTHPLACE (City and state or country) <u>Worth Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Hanigan Stone</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda Clutter</u>			14. NAME OF HUSBAND OR WIFE <u>Gertrude Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, pp or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. [Redacted]		17. INFORMANT Address <u>Mrs. Gertrude Stone, Parnell, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Artery Disease</u>							?
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post-Intubation larynx open redness</u>						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.) <u>None</u>			
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 <u>2/8/63</u> to <u>2/28/63</u> and last saw him alive on <u>2/27/63</u> Death occurred at <u>5:20 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u>			(Degree or title) <u>M. D.</u>		22b. ADDRESS <u>Maryville, Missouri</u>		22c. DATE SIGNED <u>3/4/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>3/3/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		23d. LOCATION (City, town, or county) <u>Parnell, Missouri</u>		
24. FUNERAL DIRECTOR <u>Price Funeral Home, Maryville, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>3-4-63</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

SP-100-207

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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 *J. Merrick*

Licensed Embalmer No. 5188

P. O. Address Springville, 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.