

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-010600

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **43** Primary Registration District No. **30071** Registrar's No. **14091**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 **0128**
2 **0120**
3
4 **0**
5 **2**
6
7 **0**
8 **1**
9 **9163XA**
10
11
12 **5-0**
13 **1-0**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BUTLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 37 DAYS	c. CITY OR TOWN NEELYVILLE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) GEN. DEL. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle L. Last DAVENPORT			4. DATE OF DEATH Month MARCH Day 4 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 12-29-77
9. AGE (last birthday) 85		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) GILLIAM, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME GEORGE R. DAVENPORT	
13b. MOTHER'S MAIDEN NAME SUSAN WARSON		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) YES SPAW		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT VA. HOSPITAL RECORDS, POPLAR BLUFF, MO. Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL			INTERVAL BETWEEN ONSET AND DEATH ---
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA OF LUNG, RIGHT WITH METASTASIS TO MEDIASTINUM AND LEFT LUNG			---
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PULMONARY TUBERCULOSIS		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.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> VA		
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 1-25-63 to 3-4-63 and last seen alive on _____ Death occurred at 11:55PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) DAVID T. MILLER M.D. Actg. Pathologist		22b. ADDRESS VA. HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 3-5-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR. 7 - 1963	23c. NAME OF CEMETERY OR CREMATORY DUNNING CEMETERY	23d. LOCATION (City, town, or county) (State) BUTLER CO. MO.
24. FUNERAL DIRECTOR PARRENT FUNERAL HOME NAYLOR, MO.		25. DATE RECD. BY LOCAL REG. 3/14/1963	26. REGISTRAR'S SIGNATURE Thelma Graham

USE BLACK INK OR TYPEWRITER RIBBON

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

Gene H. Perrent

Licensed Embalmer No. 4809

P. O. Address Naylor, 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.