

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012461

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. \_\_\_\_\_ Registrar's No. 9

**FILED APR 4 1963**

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence Before admission) a. STATE <u>Mo</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Palmyra</u>		Length of stay in 1b <u>2 years</u>	c. CITY OR TOWN <u>Warren</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Maple Lawn Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route Z</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Joseph Terrill</u>			4. DATE OF DEATH Month Day Year <u>March 20, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/81</u>
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>	11. BIRTHPLACE (City and state or country) <u>Marion Co. Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>William Terrill</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Atkinson</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Carter Terrill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Wilfred Terrill, Quincy, Illinois</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of sigmoid Colon</u> DUE TO (b) <u>also a cardiac condition</u> DUE TO (c) <u>along with suppuratives</u> 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			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
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 <u>Nov. 62</u> to <u>Mar. 63</u> and last saw him alive on <u>March 17/63</u> Death occurred at <u>7:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>P. H. Stuklman M.D.</u>		22b. ADDRESS <u>Palmyra Mo</u>	22c. DATE SIGNED <u>3-22-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/23/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Andrew Chapel Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Warren Missouri</u>
24. FUNERAL DIRECTOR <u>Harold V. Garner, Monroe City Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-25-63</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luchs</u> <u>By Viola Gee, Deputy</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59  
10641  
20640  
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5 2  
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12 86-2  
13 1-0

**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 Wm. R. Turner

Licensed Embalmer No. 3720

P. O. Address Monroe 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.