

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012823

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 297 Primary Registration District No. 4022 Registrar's No. 56

FILED APR 9 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Ray</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>                      |                                                                 |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Richmond Twp</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | Length of stay in lb <u>4 Days</u>                                                                                                                          |                                                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Ray CO. Memorial Hospt.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                        |                                                                 |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Cornelia</u> Middle <u>Jane</u> Last <u>James</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>25</u> Year <u>1963</u>                                                                                       |                                                                 |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. COLOR OR RACE<br><u>White</u>                                                                          | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug II-1870</u>                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housekeeping</u>                                                                                                    |                                                                 |
| 13a. FATHER'S NAME<br><u>William Grace</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Thomson</u>                                                                                                            |                                                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>None</u>                                                                                                                      |                                                                 |
| 17. INFORMANT<br><u>Albert James, Lawson, Missouri</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 14. NAME OF HUSBAND OR WIFE<br><u>Arthur James</u>                                                                                                          |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u><br>DUE TO (b) <u>CORONARY THROMBOSIS</u><br>DUE TO (c) <u>Arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                                           | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                            |                                                                 |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" 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<br>Hour <u>6:35</u> a.m. <u>p.m.</u> Month, Day, Year <u>3/13/63</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 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<br><u>Lawson</u> COUNTY <u>Missouri</u> STATE <u>Missouri</u>                                                                  |                                                                 |
| 21. I attended the deceased from <u>3/13/63</u> to <u>3/25/63</u> and last saw her alive on <u>3/25/63</u><br>Death occurred at <u>6:35</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | 22a. SIGNATURE<br>(Deceased or title)<br><u>Colvin Wilson, D.O.</u>                                                                                         |                                                                 |
| 22b. ADDRESS<br><u>1815 Main Nigginsville, Mo.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 22c. DATE SIGNED<br><u>3/27/63</u>                                                                                                                          |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23b. DATE<br><u>3/27/1963</u>                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Union</u>                                                                                                          | 23d. LOCATION (City, town, or county)<br><u>Lawson Missouri</u> |
| 24. FUNERAL DIRECTOR<br><u>Jarman Funeral Home, Lawson, Mo.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><u>4-1-1963</u>                                                                                                             |                                                                 |
| 26. REGISTRAR'S SIGNATURE<br><u>Malcolm Guckerson</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                                                 |

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

*Lindell Jarman*

Licensed Embalmer No. 4589

P. O. Address

*Enclison Springs 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.