

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014739

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 374 Primary Registration District No. 4677 Registrar's No. 8

FILED APR 5 1963

VS 300
Rev. 4/59

1 1130

2 1130

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12 90-0

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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 Worth		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, give TOWNSHIP only) Grant City		Length of stay in 1b life	c. CITY OR TOWN Grant City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 308 W 4th		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 308 W 4th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Wilsie Station			4. DATE OF DEATH Month March Day 5 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	9. AGE (last birthday) 89 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. FATHER'S NAME W. M. Station		11b. MOTHER'S MAIDEN NAME Hanah Jane	12. CITIZEN OF WHAT COUNTRY U. S.
13a. FATHER'S NAME W. M. Station		13b. MOTHER'S MAIDEN NAME Hanah Jane	14. NAME OF HUSBAND OR WIFE Alice Trizza Station
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address Mrs. Ocle Lamb - Clarinda, Iowa
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte imbalance due to Severe Diarrhea			INTERVAL BETWEEN ONSET AND DEATH 2 Days
DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis, generalized			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.)	
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 1961 to 5 March 63 and last saw her him alive on 5 March 63 Death occurred at 4pm m on the date stated above, and to the best of my knowledge, from the causes stated.			
Signature of Affiant (Name, Degree or Title) Frank B Matteson MD		22b. ADDRESS Grant City, MO	22c. DATE SIGNED 3/6/63
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3-7-1963	23c. NAME OF CEMETERY OR CREMATORY Honey Groove Cemetery	23d. LOCATION (City, town, or county) (State) Worth County, Missouri
24. FUNERAL DIRECTOR Bill A. Dunfee Grant City		25. DATE RECD. BY LOCAL REG. April 3, 1963	26. REGISTRAR'S SIGNATURE Leto E. Dawson

(Licensed Embalmer's Statement on Reverse Side)

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 Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address Grant 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.