

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015450

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 87 Primary Registration District No. 4565 Registrar's No. 40

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10281

20263

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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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Crawford</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sullivan</u>		c. CITY OR TOWN <u>Sullivan</u>	
Length of stay in 1b <u>5 Days</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sullivan Comm. Hosp.</u>		d. STREET ADDRESS (if outside, give location) <u>*****</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last			4. DATE OF DEATH Month Day Year
<u>Annie Eliza Gargus</u>			<u>May 3, 1963</u>
5. SEX <u>Female</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>9/22/1869</u>
9. AGE (last birthday) <u>93</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (City and state or country) <u>Calloway Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John A. Boone</u>	
13b. MOTHER'S MAIDEN NAME <u>Vaughn</u>		14. NAME OF HUSBAND OR WIFE <u>Mathias Gargus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Earl Gargus, Sullivan, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u>			<u>45 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial Fibrillation</u>			<u>6 wks</u>
DUE TO (c) <u>Myocardial Disease</u>			<u>24h.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac De-compensation & Hypertrophy</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.)	
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>4-23-63</u> to <u>5-3-63</u> and last saw her alive on <u>5-3-63</u>			
Death occurred at <u>11:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>William H. Williams D.O.</u>		22b. ADDRESS <u>445 S. Main St. St. Charles</u>	22c. DATE SIGNED <u>5-5-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/6/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Mem. Cem.</u>	23d. LOCATION (City, town, or county) <u>Sullivan, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.M. Eaton, Sullivan, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 6, 1963</u>	26. REGISTRAR'S SIGNATURE <u>William Cowan</u>

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

Harrison W. Eaton

Licensed Embalmer No. 5266

P. O. Address Sullivan, 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.