

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-015499

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 99 Primary Registration District No. _____ Registrar's No. 29

FILED MAY 7 1963

VS 300
Rev. 4/59

10320

20320

3

4 1

5 2

6

7 0

8 0

94222

10

11

1290-2

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Amity</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Amity</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home In town</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Amity Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E. Wright</u> Last _____			4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>63</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>10-21-1857</u>
9. AGE (last birthday) <u>105</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and state or country) <u>Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Will Yalley</u>	
13b. MOTHER'S MAIDEN NAME <u>Sara Stevens</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of _____) <u>no</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Sara Weaver</u> Address <u>Amity Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Fatigue</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) _____			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 checked="" 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>6/10/1945</u> to <u>4/21/63</u> and last saw her alive on <u>4/21/63</u> Death occurred at <u>9:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE <u>Sharon Fowler M.D.</u> (Degree or title)		21b. ADDRESS <u>Maysville MO</u>	21c. DATE SIGNED <u>4/23/63</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE <u>4-24-63</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Amity</u>	22d. LOCATION (City, town, or county) <u>Amity Mo.</u> (State)
24. FUNERAL DIRECTOR <u>John Brown</u> ADDRESS <u>Maysville Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-29-1963</u>	26. REGISTRAR'S SIGNATURE <u>Bertie E. Davidson</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 John Brown

Licensed Embalmer No. 3933

P. O. Address Marionville 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.