

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-015854

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 423 Primary Registration District No. 4231 Registrar's No. 20

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howell</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn. View, Mo.</u> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u> c. CITY OR TOWN <u>Mtn. View</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Walter</u> Middle <u>Kondruk</u> Last _____ 4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1963</u>		5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</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>5/18/82</u> 9. AGE (last birthday) <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) <u>Australia</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Unknown</u> 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> 14. NAME OF HUSBAND OR WIFE _____	
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>Thelma Schweighouser Smoville, Mo.</u> Address _____		<b>18. CAUSE OF DEATH</b> (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>ASHD</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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>Apr. 29</u> to <u>Apr. 30</u> and last saw her/him alive on <u>Apr. 29</u> Death occurred at <u>Apr. 29, 1963</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M.C. Walton M.D.</u> 22b. ADDRESS <u>Mtn View, Mo.</u> 22c. DATE SIGNED _____		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>5-7-1963</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Summersville Cem.</u> 23d. LOCATION (City, town, or county) (State) <u>Summersville, Missouri</u>	
24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn. View, Mo.</u> ADDRESS _____ 25. DATE RECD. BY LOCAL REG. <u>5-3-1963</u> 26. REGISTRAR'S SIGNATURE <u>Charles D. Cantain</u>		(Licensed Embalmer's Statement on Reverse Side)	

VS 300 Rev. 4/59  
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2 04602  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

To Doctor: 4: P.M. 4/30/63

Rec'd from Dr. 8:15 A.M. 5/3/63

To Local Registrar 8:15 A.M. 5/3/63

Burial Permits issued 5-7-1963

MAY 28 1963

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

*Charles D. Pastain*

Licensed Embalmer No. 5107

P. O. Address W. W. Union, 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.