

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-016497

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 155 Primary Registration District No. 4244 Registrar's No. 74 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0490

2 0490

3

4 0

5 1

6

7 1

8 2

94201

10

11

12 90-8

13 1-0

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

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| <b>FILED MAY 6 1963</b>   |   | 1. PLACE OF DEATH<br>a. COUNTY <b>Jasper</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>                            |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Carterville</b>   |   | Length of stay in 1b<br><b>6 yrs.</b>   |   | c. CITY OR TOWN <b>Carterville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>420 W. Daugherty</b>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS (If outside, give location)<br><b>420 W. Daugherty</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>          |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Grover</b> Middle <b>O.</b> Last <b>Umbaugh</b>   |   |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>24</b> , Year <b>1963</b> |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-15-1885</b>                                    | 9. AGE (last birthday)<br><b>78</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired farmer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (City and state or country)<br><b>Iowa</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                   |
| 13a. FATHER'S NAME<br><b>Elias Umbaugh</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Eva Umbaugh</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Mrs. Eva Umbaugh</b> Address <b>420 W. Daugherty Carterville, Mo.</b>  |   |
| 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) <b>Coronary Occlusion</b>   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>          |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ s.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 _____   |
| <b>Cause of death determined by J.J. Royce M.D. Sarcoxie</b>  |   |   |   |  |   |
| 21. I attended the deceased from _____ to _____ and last saw him alive on _____<br>Death occurred at <b>Unattended 11:15 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated. <b>Mo.</b> |   |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>Mrs. Madeline Switzer L.R.</b>   |   |   | 22b. ADDRESS<br><b>Webb City, Mo.</b>                                   |  | 22c. DATE SIGNED<br><b>4-25-63</b>                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |   | 23b. DATE<br><b>4-25-63</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Afton Cemetery</b>             |  | 23d. LOCATION (City, town, or county)<br><b>Afton, Iowa</b> |
| 24. FUNERAL DIRECTOR<br><b>Johnston-Simpson, Webb City, Mo.</b>   |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>4-25-63</b>                          | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Madeline Switzer</b>  |   |

8913  
5 of 10

**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 Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address Webb 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.