

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-016813

STATE FILE NUMBER

Registration District No. 210 Primary Registration District No. _____ Registrar's No. 35

FILED MAY 14 1963

DO NOT WRITE ON THIS STUD

AMENDED

VS 300
Rev. 4/59

1 0650
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942228
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Mercer</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Medicine Township</u>		Length of stay in 1b <u>4 wks.</u>	c. CITY OR TOWN <u>Harris</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>4 mi. E. Spickard</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Harris</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dott</u> Middle <u>M.</u> Last <u>Baldrige</u>			4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-87</u>
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	9. AGE (last birthday) <u>76</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11. BIRTHPLACE (City and state or country) <u>Milan, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Alexander Mayhough</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha West</u>	14. NAME OF HUSBAND OR WIFE <u>George W. Baldrige</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs Lonnie Wendt, Spickard, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>chronic myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>gangrenous ulcer</u>			<u>2 mo</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>fracture surgical neck left hip</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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>1/15/63</u> to <u>5/8/63</u> and last saw him alive on <u>5/11/63</u>		Death occurred at <u>4:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>D. W. Hall, D.O.</u> (Degree or title)		22b. ADDRESS <u>Harris Mo</u>	22c. DATE SIGNED <u>5/9/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5-10-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brackett</u>	23d. LOCATION (City, town, or county) (State) <u>Sullivan Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Judd & Payne, Newtown, Mo.</u>		25. DATE REGD. BY LOCAL REG. <u>5-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Hall</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 T. Howard Deibel

Licensed Embalmer No. 3940

P. O. Address Quinton 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.

5-9-63

Permit to be buried 5-9-63 M.M.