

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019817

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 740

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 20 1963

VS 300
Rev. 4/59

10397
20390

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>Years</u>		c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt 9</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Marie</u> Last <u>Young</u>			4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>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>6-7--1876</u>	9. AGE (last birthday) <u>87</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>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Chadwick Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Abe Teague</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Elick</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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> <u>none</u>			16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT <u>John Young</u> Address <u>Rt 9 Springfield, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</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>5/2/63</u> to <u>5/14/63</u> and last saw her <u>alive</u> on <u>5/14/63</u> Death occurred at <u>1:10 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Leman D. Brown MD</u>			22b. ADDRESS <u>311 1/2 College</u>		22c. DATE SIGNED <u>5/15/63</u>		
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-16-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Galloway Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Galloway Missouri</u>		
24. FUNERAL DIRECTOR <u>Chapel of the Ozarks Inc</u> ADDRESS <u>Springfield Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>5-17-63</u>		26. REGISTRAR'S SIGNATURE <u>Effie B Melton</u> EW		

(Licensed Embalmers' Statement on Reverse Side)

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

Horavon B. Lakin

Licensed Embalmer No. 5159

P. O. Address Springfield, 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.

Permit 5-15-63