

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-019925

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 4234 Registrar's No. 72

FILED JUN 10 1963

1. PLACE OF DEATH a. COUNTY <p style="text-align: center;">Iron</p>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <p style="text-align: center;">State</p>		b. COUNTY <p style="text-align: center;">Washington</p>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <p style="text-align: center;">Ironton</p>		Length of stay in 1b <p style="text-align: center;">3 days</p>		c. CITY OR TOWN <p style="text-align: center;">Mineral Point</p>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <p style="text-align: center;">St. Mary's Hosp.</p>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <p style="text-align: center;">None</p>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <p style="text-align: center;">MARY Josephine DEGONIA</p>			4. DATE OF DEATH Month Day Year <p style="text-align: center;">May 28 1963</p>		
5. SEX <p style="text-align: center;">Female</p>	6. COLOR OR RACE <p style="text-align: center;">White</p>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <p style="text-align: center;">9/10/92</p>	9. AGE (last birthday) <p style="text-align: center;">70</p>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">Housewife</p>		10b. KIND OF BUSINESS OR INDUSTRY <p style="text-align: center;">Own Home</p>		11. BIRTHPLACE (City and state or country) <p style="text-align: center;">Old Mines, Mo.</p>	
12. CITIZEN OF WHAT COUNTRY <p style="text-align: center;">USA</p>		13a. FATHER'S NAME <p style="text-align: center;">Julius LaChance</p>		13b. MOTHER'S MAIDEN NAME <p style="text-align: center;">Catherine Politte</p>	
14. NAME OF HUSBAND OR WIFE <p style="text-align: center;">Henry Lonnie DeGonia</p>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p style="text-align: center;">No</p>		16. SOCIAL SECURITY NO.	
17. INFORMANT <p style="text-align: center;">Henry DeGonia</p>		Address <p style="text-align: center;">Mineral Point, Mo.</p>			

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>Cerebral Hemorrhage (stroke)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5/28/63</u> <u>??</u>
DUE TO (b) <u>Hypertensive Heart Disease</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>Advanced arteriosclerosis, hypertension, diabetes mellitus, (3) angina pectoris</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>5/25/63</u> to <u>5/28/63</u> and last saw her alive on <u>5/27/63</u> . Death occurred at <u>5/28/63 6:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>R. E. Harland, M.D.</u>	22b. ADDRESS <u>Ironton, Mo.</u>	22c. DATE SIGNED <u>5/28/63</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <p style="text-align: center;">Removal</p>	23b. DATE <p style="text-align: center;">5/30/63</p>	23c. NAME OF CEMETERY OR CREMATORY <p style="text-align: center;">Calvary Cemetery</p>	23d. LOCATION (City, town, or county) (State) <p style="text-align: center;">Potosi Mo.</p>
24. FUNERAL DIRECTOR ADDRESS <p style="text-align: center;">Gum & Son Potosi, Mo.</p>	25. DATE RECD. BY LOCAL REG. <p style="text-align: center;">6-1-63</p>	26. REGISTRAR'S SIGNATURE <p style="text-align: center;">Mrs. Aris Jones</p>	

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
 1 0470
 2 1100
 3
 4 1
 5 1
 6
 7 0
 8 2
 9 9443X
 10
 11
 12 1-0
 13 1-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 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 William H. Green

Licensed Embalmer No. 5155

P. O. Address Potosi, 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.