

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021028
STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 120

FILED MAY 22 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0817
2 0280
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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

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Length of stay in 1b <u>2 Months</u>	c. CITY OR TOWN <u>Steelville</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>McFarland Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Huzzah Route</u>		
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>- - -</u> Last <u>SETZER</u>			4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1963</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/1893</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Davisville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Logan E. Setzer</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Andrews</u>		14. NAME OF HUSBAND OR WIFE <u>Florence Setzer</u>		
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 Address <u>Lucille Eaglin, Steelville, 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>Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</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) <u>Cerebral Vascular Accident</u>					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 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>March 1963</u> , to <u>May 15, 1963</u> and last saw ^{her} him alive on <u>May 15, 1963</u> Death occurred at _____ on the _____ date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Dr. Anderson</u> (Degree or title)			22b. ADDRESS <u>Rolla Mo.</u>		22c. DATE SIGNED <u>5-15-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/18/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Czar Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Crawford County, Mo.</u>		
24. FUNERAL DIRECTOR <u>Halbert Funeral Home, Steelville, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>May 15, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>		

USE BLACK INK OR TYPEWRITER RIBBON

MAY 23 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 Thomas S. Halbert

Licensed Embalmer No. 4332

P. O. Address Steelyville, 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.