

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024143

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 2444 Primary Registration District No. 4234 Registrar's No. 84

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Iron</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ironton</u> Length of stay in 1b <u>2 yrs</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>Iron</u></p> <p>c. CITY OR TOWN <u>Ironton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>227 N. Mountain</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED First Middle Last (Type or print) <u>CHARLES BERNARD WHELEHON</u></p>		<p>4. DATE OF DEATH Month Day Year <u>June 19 1963</u></p>					
<p>5. SEX <u>male</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Jan. 17 1907</u></p>	<p>9. AGE (last birthday) <u>56</u></p>	<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.</p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (City and state or country) <u>Arcadia Mo.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	
<p>13a. FATHER'S NAME <u>Charles Whelehon</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Martha Hansbrough</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Mildred Whelehon</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW 2</u></p>			<p>17. INFORMANT Address <u>Mildred Whelehon, Ironton Mo.</u></p>				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u></p> <p style="text-align: center;">DUE TO (b)</p> <p style="text-align: center;">DUE TO (c) <u>Phlebothrombosis of leg</u> <u>1 week</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of Pancreas</u></p> <p>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</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>					
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>					
<p>21. I attended the deceased from <u>Jan 15 1963</u>, to <u>June 17 1963</u> and last saw her alive on <u>June 18, 1963</u> Death occurred at <u>4:10 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p>22a. SIGNATURE (Degree or title) <u>Marvin C. Kennedy MD</u></p>			<p>22b. ADDRESS <u>Ironton</u></p>		<p>22c. DATE SIGNED <u>6-19-63</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></p>		<p>23b. DATE <u>6-21-63</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Arcadia Valley Memorial Park, Ironton Mo.</u></p>		<p>23d. LOCATION (City, town, or county) (State)</p>		
<p>24. FUNERAL DIRECTOR ADDRESS <u>White Funeral Home, Ironton Mo.</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>6-20-63</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Mrs. Avis Jones</u></p>				

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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

JUN 26 1963

FEB 4 1964

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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 Max V. White

Licensed Embalmer No. 5077

P. O. Address Ironton, Ma

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.