

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025588

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 259

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JUN 26 1963**

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Knob Lick</b>		Length of stay in 1b	c. CITY OR TOWN: <b>Knob Lick, Mo.</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural Route</b>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Julian</b> Last <b>Stuckey</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/1945</b>
9. AGE (last birthday) <b>18</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Russell Edward Stuckey</b>	
13b. MOTHER'S MAIDEN NAME <b>Juanita Greer</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>R.W. Greer</b>		Address <b>Knob Lick, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute peripheral circulatory collapse</b> DUE TO (b) <b>toxic hepatitis</b> DUE TO (c) <b>amepholaxis of myocardium</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>3 days</b>
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 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 <b>June 21, 63</b> to <b>June 21, 63</b> and last saw him live on <b>June 21, 63</b> Death occurred at <b>12:25 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <b>D.O. Farmington, Mo.</b>	22c. DATE SIGNED <b>6/22/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June, 23/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HillView Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Near Farmington Missouri</b>
24. FUNERAL DIRECTOR <b>C.H. Cozean</b>		ADDRESS <b>Farmington, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>June 22, 1963</b>
		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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

VS 300 Rev. 4/59

18940

20940

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JUL 1 1968

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 \_\_\_\_\_

*A. Cozart*

Licensed Embalmer No. 4084

P. O. Address Farmington 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.