

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026982

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 98

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 98

FILED JUN 20 1963

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Length of stay in 1b <u>4 days.</u>	c. CITY OR TOWN <u>Niangua</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>-</u> Last <u>Franz</u>			4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1963</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-2-1867</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Months Days Hours Min.	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>-</u>		11. BIRTHPLACE (City and state or country) <u>Webster Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Silas White</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Brankley</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>			16. SOCIAL SECURITY NO. <u>[Redacted]</u>		17. INFORMANT Address <u>State Hospital Records</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>Arteriosclerotic Heart Disease</u> Interval between onset and death <u>years</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>Generalized Arteriosclerosis</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 June 4, 1963 to June 8, 1963 and last saw her alive on June 8, 1963
Death occurred at 3:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3-Nevada, Mo</u>	22c. DATE SIGNED <u>6-8-1963</u>
-----------------------------------------------------------	-----------------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6-8-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MARSHFIELD</u>	23d. LOCATION (City, town, or county) (State) <u>MARSHFIELD MO</u>
-------------------------------------------------------------	------------------------------	---------------------------------------------------------	-----------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS <u>BARBER-EDWARDS MARSHFIELD</u>	25. DATE RECD. BY LOCAL REG. <u>6-14-1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
------------------------------------------------------------------	--------------------------------------------------	-------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

VS 300	DATE AMENDED
Rev. 4/59	
1 <u>1080</u>	
2 <u>1120</u>	
3	
4 <u>1</u>	
5 <u>3</u>	
6	
7 <u>0</u>	
8 <u>3</u>	
9 <u>94200</u>	
10	
11	
12 <u>93-0</u>	
13 <u>1-0</u>	

USE BLACK INK
 OR
 TYPEWRITER RIBBON

MISSOURI

1080
1104
1
8
0
8

0-89

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 George Stapp

Licensed Embalmer No. 3161

P. O. Address W. E. Jones, 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.