

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-031777**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 111

**FILED AUG 26 1963**

1. PLACE OF DEATH a. COUNTY <b>Cooper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Cooper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Boonville</b>		Length of stay in 1b <b>5 Years.</b>	c. CITY OR TOWN <b>Bunceton</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle Last <b>Whitaker</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1963</b>	
5. SEX <b>Female</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>Nov. 6, 1896</b> 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>	11. BIRTHPLACE (City and state or country) <b>Cooper County, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Wm. Platt Whitaker</b>	
13b. MOTHER'S MAIDEN NAME <b>Clara Beall McCullach</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. [REDACTED]	
17. INFORMANT <b>Mrs. F. E. Filler, Bunceton, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT MENINGEOMA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 YEARS.</b>
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) <b>ARTERIO-SCLEROTIC HEART DISEASE</b>			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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>7/12/63</b> to <b>8/18/63</b> and last saw her alive on <b>8/18/63</b> Death occurred at <b>9:15</b> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>A. Filler, M.D.</i> (Degree or title)		22b. ADDRESS <b>229 MAIN ST. BOONVILLE, MO</b>	22c. DATE SIGNED <b>8/22/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 20, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bunceton Masonic Cemetery, Bunceton, Mo.</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>Goodman &amp; Boller, Boonville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8/22/63</b>	26. REGISTRAR'S SIGNATURE <i>J. Cooper</i>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300  
Rev. 4/59

10275  
20270

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9/93.2

JUL 13 1966

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 \_\_\_\_\_ Signed William W. Wood  
Signature of Student Embalmer

Licensed Embalmer No. 4539

P. O. Address Boonville, 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.