

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033154

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 174

DO NOT WRITE ON THIS STUD

AMENDED

FILED SEP 6 1963

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		c. CITY OR TOWN <u>Rolla</u>	
Length of stay in 1b		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>McFarland Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>McFarland</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Alva</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>6/12/1877</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u> Hours <u></u> Min. <u></u>
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>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>					

13a. FATHER'S NAME <u>Calaway Bown</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>John Wilson Newburg, 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>Degeneration Heart disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u> 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>					
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 <u>Rolla Mo</u>	
20g. COUNTY <u></u>		20h. STATE <u></u>			

21. I attended the deceased from <u>7/9/63</u> to <u>8/7/63</u> and last saw <sup>him</sup> <u>him</u> alive on <u>8/7/63</u>	
Death occurred at <u>530 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>Lee Johnson</u> (Degree of title)		22b. ADDRESS <u>Rolla Mo</u>		22c. DATE SIGNED <u>8/9/63</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/11/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Roach Cemetery</u>		23d. LOCATION (City, town, or county) <u>No. of Newburg, Mo</u>	
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24. FUNERAL DIRECTOR <u>Lee Johnson F. H. Newburg, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 20, 1963</u>		26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>	
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

VS 300	Rev. 4/59
10817	
20817	
3	
4	0
5	2
6	
7	1
8	2
9	422.1
10	
11	
12	86-0
13	1-0

INSTEAD OF


DOCUMENT


MEDICAL CERTIFICATION


BY AFFIDAVIT OF


SHOULD READ


ITEM NO.


USE BLACK INK OR TYPEWRITER RIBBON

**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 W. L. Strawhun

Licensed Embalmer No. 5043

P. O. Address Newburg, 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.