

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034911

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 373 Primary Registration District No. 6265 Registrar's No. 34

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 9 1963

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN GRANT TWP	Length of stay in 1b 7 YRS	c. CITY OR TOWN MARSHFIELD	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7 MI WEST	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MARCUS RHEA WAADROP			4. DATE OF DEATH Month Day Year SEPT 4 1963			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1915	9. AGE (last birthday) 48	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PET COOK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) TEXAS		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME JOHN WAADROP		13b. MOTHER'S MAIDEN NAME ELENE HARRISON		14. NAME OF HUSBAND OR WIFE BERNICE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of serv) YES WW2		16. SOCIAL SECURITY NO.		17. INFORMANT Address BERNICE WAADROP, MARSHFIELD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown Natural Cause		INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last. DUE TO (b) Tuberculosis, Advanced		Over 10 yrs
DUE TO (c) Malnutrition - Coronary Heart Disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Alcoholism - Bronchial Asthma, Chronic		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 **Dec. 1956** to **June 29, 1963** and last saw him alive on **June 29, 1963**
Death occurred at **6 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C.R. Macdonnell M.D.	22b. ADDRESS Marshfield, Mo.	22c. DATE SIGNED (State) 9/5/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-6-1963	23c. NAME OF CEMETERY OR CREMATORY NATIONAL	23d. LOCATION (City, town, or county) (State) SPRINGFIELD MO
24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD	25. DATE RECD. BY LOCAL REG. 9-6-63	26. REGISTRAR'S SIGNATURE [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
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 2 1120
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 9 954
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
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SEP 10 1968

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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 George Stapp

Licensed Embalmer No. 3161

P. O. Address Mr. Stapp, MD

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.