

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034932

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 317

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 7 1963

VS 300
Rev. 4/59

0017
8030

3
4 1
5 1
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7 1
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9 1750
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12 1-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkeville		c. CITY OR TOWN Pineville	
Length of stay in 1b 3 weeks		d. STREET ADDRESS (If outside, give location) RURAL	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim-Smith Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Ethel Grace Dillard			4. DATE OF DEATH Month Day Year September 18, 1963		
5. SEX Female	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 7-30-1902	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Farm home		11. BIRTHPLACE (City and state or country) Mena, Arkansas	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John Lofton		13b. MOTHER'S MAIDEN NAME Elizabeth Beeler	
14. NAME OF HUSBAND OR WIFE Isom Rupert Dillard		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) No		17. INFORMANT Rupert Dillard, Pineville, Ark.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
IMMEDIATE CAUSE (a) Pseudomucous cysto adenocarcinoma left ovary with metastasis.		
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) None		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 <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 checked="" 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 8-27-63 to 9-18-63 and last saw her alive on 9-18-63
Death occurred at 5:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Norton T. Reed, M.D.</i>	22b. ADDRESS Kirkville, Missouri	22c. DATE SIGNED 9-18-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-21-1963	23c. NAME OF CEMETERY OR CREMATORY Overstreet Cemetery
23d. LOCATION (City, town, or county) Sullivan Co., Mo.		(State)

24. FUNERAL DIRECTOR <i>Glenn E. Kenton, Green City, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Sept 30, 1963</i>	26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

Print name Sept 18, 1963

MILTON T. ENGLISH, M.D.

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, 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.