

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035123

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 40056 Registrar's No. 636

**FILED SEP 20 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Boone</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hallsville</b>		Length of stay in 1b <b>2 months</b>		c. CITY OR TOWN <b>Hallsville</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>Hartley Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Hartley Nursing Home</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rosie</b> Middle <b>Belle</b> Last <b>Wheeler</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>17</b> Year <b>1963</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <b>3/7/1874</b>		9. AGE (last birthday) <b>89</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>		11. BIRTHPLACE (City and state or country) <b>Boone County, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Silas M. Wainscott</b>		13b. MOTHER'S MAIDEN NAME <b>Rosie Ann Roberts</b>	
14. NAME OF HUSBAND OR WIFE <b>DEA</b>		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. Glenn Ridgway, Hallsville, Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> Senile Debility Emaciation and malnutrition Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
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 . . . . . Month, Day, Year a.m. . . . . p.m. . . . .		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>8-15-63</b> to <b>9-17-63</b> and last saw her alive on <b>9-17-63</b> Death occurred at <b>six o'clock P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Walter Sparks</i> D.O.			22b. ADDRESS <b>311 Christian College Ave</b> <b>Columbia, Mo.</b>		22c. DATE SIGNED <b>9-18-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 19, '63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Centralia</b>	
23d. LOCATION (City, town, or county) <b>Centralia, Mo.</b>		24. FUNERAL DIRECTOR <i>Due D. Meador Centralia, Missouri</i>		25. DATE RECD. BY LOCAL REG. <b>Sept 18, 1963</b>	
26. REGISTRAR'S SIGNATURE <i>Mrs RE Palmer</i>					

USE BLACK INK OR TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

SEP 24 1963

**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

*Bice J. Meador*

Licensed Embalmer No. 4876

P. O. Address Centuria, Missouri

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.