

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035853

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 132 Primary Registration District No. _____ Registrar's No. 164

FILED SEP 16 1963

VS 300	DATE AMENDED
Rev. 4/59	
1 04100	
2 1050	
3	
4 0	
5 2	
6	
7 0	
8 0	
9 180X	
10	
11	
12 86-2	
13 1-0	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

1. PLACE OF DEATH a. COUNTY <u>Grundy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Henton Twp.</u>		Length of stay in 1b <u>1 mo.</u>	c. CITY OR TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Maniraw Rest Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Liberty Twp.</u>
3. NAME OF DECEASED (Type or print) First <u>OLAN</u> Middle <u>LEVI</u> Last <u>COURTNEY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>11-17-1883</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sullivan Co Mo</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Joseph Courtney</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Knowles</u>		14. NAME OF HUSBAND OR WIFE <u>Matthie Foster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates)		16. SOCIAL SECURITY NO. <u>948</u>	17. INFORMANT <u>Mr CW Johnson</u> Address <u>Galt 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>Cancer Lung Stage 3</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Cancer</u>			<u>1 year</u>
DUE TO (c) <u>Cancer of Kidney</u>			<u>2 years</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 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 <u>1950</u> to <u>1963</u> and last saw her/him alive on <u>9-5-63</u> . Death occurred at <u>9-6-63 12:05P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Archie M</u> (Degree or title)		22b. ADDRESS <u>Galt Mo</u>	22c. DATE SIGNED <u>9-7-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>9-8-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berry Cem.</u>	23d. LOCATION (City, town, or county) <u>Galt Mo</u> (State)
24. FUNERAL DIRECTOR <u>Rayne Funeral Home</u> ADDRESS <u>Galt Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-7-63</u>	26. REGISTRAR'S SIGNATURE <u>Gene Fair</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 P. R. Payne Jr.

Licensed Embalmer No. 3400

P. O. Address Galt

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.