

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036788

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 317

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 30 1963

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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 <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u> Length of stay in 1b. <u>26 days</u>		c. CITY OR TOWN <u>Ar cols</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Old Miss. State Sanet</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>R I</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED. (Type or print) First <u>Fred</u> Middle <u>Baker</u> Last			4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>63</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>3. 24. 79</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>	9. AGE (last birthday) <u>84 yrs.</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11a. FATHER'S NAME <u>William Henry Baker</u>		11b. MOTHER'S MAIDEN NAME <u>Susan Torrence</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		12b. SOCIAL SECURITY NO. <u>Missouri State Sanatorium</u> Address	
13. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Haemorrhage</u> DUE TO (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH. <u>few</u> <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease, Compensated</u>			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
14. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	15. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	16. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
17. TIME OF INJURY Hour Month, Day, Year			
18. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		19. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>9. 29, 63</u> to <u>9. 24 63</u> and last saw her alive on <u>9. 24-63</u> Death occurred at <u>11-50 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. Vernon Langcutting M.D. Mo SS Mt. Vernon, Mo</u>		22b. ADDRESS <u>9. 24-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-27-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Younger Cemetery</u>		23d. LOCATION (City, town, or county) <u>Cedar County, Mo.</u>	
24. FUNERAL DIRECTOR <u>Carlton F. Hare</u> ADDRESS <u>Stockton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-26-63</u>	
26. REGISTRAR'S SIGNATURE <u>Loy Shanthro</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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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,

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or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address Merron, 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.