

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-039099**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1857

**FILED NOV 4 1963**

VS 300  
Rev. 4/59

1 0129  
2 8030  
3  
4 0  
5 1  
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7 1  
8 1  
9 4920

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ARKANSAS</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>22 DAYS</b>	c. CITY OR TOWN <b>KNOBEL</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>STAR ROUTE</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ORVILL THOMAS MONTGOMERY</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 28 1963</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-22</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRIC POWER LINEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POWER LINEMAN</b>	9. AGE (last birthday) <b>41</b>
11. BIRTHPLACE (City and state or country) <b>KNOBEL, ARKANSAS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN T. MONTGOMERY</b>		13b. MOTHER'S MAIDEN NAME <b>CARRIE H. GATLIN</b>	14. NAME OF HUSBAND OR WIFE <b>DOROTHY MONTGOMERY</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>			Address
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONITIS, BILATERAL</b>			INTERVAL BETWEEN ONSET AND DEATH -----
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <b>ASTROCYTOMA, RIGHT, TEMPORAL LOBE</b>			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 checked="" 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.) <b>VA</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>10-6-63 to 10-28-63</b>
21. I attended the deceased from <b>10-6-63</b> to <b>10-28-63</b> and last saw him on <b>10-28-63</b> Death occurred at <b>4:10 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>D. M. Wilson, M.D., Acting Pathologist</b>		22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>	22c. DATE SIGNED <b>10-28-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>11-1-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood</b>	23d. LOCATION (City, town, or county) (State) <b>Blytheville Ark.</b>
24. FUNERAL DIRECTOR <b>Cobb Funeral Home</b> <b>Blytheville Ark.</b>		25. DATE RECD. BY LOCAL REG. <b>11-1-1963</b>	26. REGISTRAR'S SIGNATURE <b>Thelma Graham</b>

USE BLACK INK OR TYPEWRITER RIBBON

JAN 15 1964

NOV 26 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



Licensed Embalmer No. 3100

P. O. Address 603 W. Main  
Blytheville Ark.

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.