

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039711

STATE FILE NUMBER

Registration District No. 142 Primary Registration District No. 4231 Registrar's No. 43

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

10460

21010

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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

FILED OCT 21 1963

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   |                                                                                                                                                          |                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Howell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Shannon</b>                    |                                                                                        |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Goldsberry</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   | c. CITY OR TOWN <b>Montier</b> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>                                             |                                                                                        |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Francis Hosp.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                   | d. STREET ADDRESS (If outside, give location)<br><b>Montier</b> Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>           |                                                                                        |
| 3. NAME OF DECEASED<br>(Type or print) First <b>William</b> Middle <b>Albert</b> Last <b>Allen</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                   | 4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1963</b>                                                                                     |                                                                                        |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. COLOR OR RACE <b>W</b>                                                                                         | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>12/2/81</b>                                                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farming</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                        | 9. AGE (last birthday) <b>81</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 11a. FATHER'S NAME <b>William Allen</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                   | 11b. MOTHER'S MAIDEN NAME <b>Louisa Lloyd</b>                                                                                                            |                                                                                        |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   | 16. SOCIAL SECURITY NO. <b>None</b>                                                                                                                      |                                                                                        |
| 17. INFORMANT <b>Opal E. Lawrence</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   | Address <b>Topeka, Kansas</b>                                                                                                                            |                                                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> 332<br>DUE TO (b) <b>Acute myocardial infarction 4201</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><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 a.m. p.m. Month, Day, Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 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>Oct 9, 1963</b> to <b>Oct. 11, 1963</b> and last saw her alive on <b>Oct. 10, 1963</b><br>Death occurred at <b>Oct. 11, 1963</b> m on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                                                                                           |                                                                                                                   |                                                                                                                                                          |                                                                                        |
| 22a. SIGNATURE (Degree or title) <b>M.C. Walton M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                   | 22b. ADDRESS <b>Mtn View, Mo.</b>                                                                                                                        |                                                                                        |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   | 23d. LOCATION (City, town, or county) (State) <b>Montier, Missouri</b>                                                                                   |                                                                                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE <b>10/12/63</b>                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY <b>Montier Cem.</b>                                                                                                   |                                                                                        |
| 24. FUNERAL DIRECTOR ADDRESS <b>Duncan Funeral Home Mtn. View, Mo.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   | 25. DATE RECD. BY LOCAL REG. <b>10-18-1963</b>                                                                                                           |                                                                                        |
| 26. REGISTRAR'S SIGNATURE <b>Charles D. Cartier</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   |                                                                                                                                                          |                                                                                        |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

To Doctor: 3: P.M. 10/11/63

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

*Charles D. Partain*

Licensed Embalmer No.

*5107*

P. O. Address

*2701 N. Union, 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.