

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040348
STATE FILE NUMBER

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 544

FILED NOV 15 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DATE AMENDED

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Jasper | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin | a. STATE Missouri | b. COUNTY Jasper |
| Length of stay in 1b 2 weeks | | c. CITY OR TOWN Webb City | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Freeman Hospital | | d. STREET ADDRESS 819 W. Broadway | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|---------------------|-----------------------------------|---|--------------------------------------|-------------------------------------|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First Nellie | Middle M. | Last Harvey | Month November | Day 5, | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-23-1881 | 9. AGE (last birthday) 82 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |

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|--|--|--|--|
| 11. BIRTHPLACE (City and state or country) Oronogo, Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Joseph Kerr | | 13b. MOTHER'S MAIDEN NAME Elizabeth Falukner | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Alice Kramer Address San Mateo, California | |

| | | |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line) | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | |
| IMMEDIATE CAUSE (a) Cardiac Arrhythmia- Type unknown | | Immediate |
| DUE TO (b) Arteriosclerotic heart disease and | | Unknown |
| DUE TO (c) Associated cardiac decompensation | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Thrombosis | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
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|---|---|--|--------------|
| 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 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 11-4-63 to 11-5-63 and last saw her/him alive on 11-5-63
Death occurred at 5:55P m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--|--|
| 22a. SIGNATURE (Degree or title) <i>Andrew J. Krutach</i> M.D. | 22b. ADDRESS 25th & Jackson, Joplin, Mo. | 22c. DATE SIGNED 11-7-63 (State) |
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| | | | |
|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 11-8-1963 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery | 23d. LOCATION (City, town, or county) Webb City, Missouri (State) |
|--|-------------------------------|--|---|

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR Johnston-Simpson, Webb City, Mo. ADDRESS | 25. DATE RECD. BY LOCAL REG. 11-13-1963 | 26. REGISTRAR'S SIGNATURE <i>Dovie Merriam</i> |
|---|---|---|

USE BLACK INK OR TYPEWRITER RIBBON

NOV 19 1963

NOV 27 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

Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address Webb City, 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.