

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040675

STATE FILE NUMBER

Registration District No. 211 Primary Registration District No. 4324 Registrar's No. 45-63

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 30 1963

1. PLACE OF DEATH a. COUNTY <u>Miller</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Miller</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tuscumbia</u>		Length of stay in 1b <u>1 WEEK</u>	c. CITY OR TOWN <u>IBERIA</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Humphrey's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Route #2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type of print) First <u>JESSE</u> Middle <u>JAMES</u> Last <u>WALL</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>19</u> Year <u>1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1887</u>
9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Trader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stockman</u>	11. BIRTHPLACE (City and state or country) <u>Iberia, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>JAMES WALL</u>	
13b. MOTHER'S MAIDEN NAME <u>Mildred JAMES</u>		14. NAME OF HUSBAND OR WIFE <u>Evelyn Blize WALL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Evelyn WALL</u> Address <u>Iberia, Mo.</u> RR# 2
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>Plasmocytoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>
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)			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 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 <u>1940</u> to <u>10/19/63</u> and last saw him alive on <u>10/19/63</u> . Death occurred at <u>5:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <u>W.M. A. Gould D.O.</u>		22b. ADDRESS <u>Iberia Mo</u>	22c. DATE SIGNED <u>10/21/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-21-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Curry Cemetery</u>	23d. LOCATION (City, town, or county) <u>Miller (state)</u> <u>Iberia, RR#2 Mo.</u>
24. FUNERAL DIRECTOR <u>SCHUNER-STEINSON</u>	ADDRESS <u>Iberia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 24, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. D. E. Kallenbach</u>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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MEDICAL CERTIFICATION

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,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Jay A. Stevenson*

Licensed Embalmer No. 5201
P. O. Address Merida, 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.