

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-040802

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 264 Primary Registration District No. 264-5885 Registrar's No. 86

STATE FILE NUMBER

**FILED NOV 13 1963**

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Ozark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Barren Fork Township</u> Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>Almartha</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		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Otis A. Herndon</u>			4. DATE OF DEATH Month Day Year <u>Oct. 28, 1963</u>		
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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>1-6-82</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter and retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Almartha, Mo.</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Francis Marion Herndon</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Malinda Milne</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Ellen Herndon</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT Address <u>Martha Ellen Herndon, Almartha, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac decompensation with edema</u>		<u>6 mo.</u>
DUE TO (b) <u>Arteriosclerosis</u>		<u>15 years</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pleural effusion</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	
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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.)	
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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.) <u>8/9/1948</u>	20f. CITY, TOWN, OR LOCATION <u>10/28/63</u>	COUNTY <u>Mo</u>	STATE <u>10/28/63</u>
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21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at <u>2:07 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>M. J. Hoerman</u> (Degree or title)	22b. ADDRESS <u>Gainesville, Mo</u>	22c. DATE SIGNED <u>11/4/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-31-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Souder</u>	23d. LOCATION (City, town, or county) (State) <u>Souder, Missouri</u>
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24. FUNERAL DIRECTOR <u>Clinkingbeard Funeral Home, Ava, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11.4-63</u>	26. REGISTRAR'S SIGNATURE <u>Barbara Shaw</u>
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Clinkingbeard Funeral Home, Ava, Mo.

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE/AMENDED

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20770

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 22 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

*Lyle S. Clinkingbeard*

Licensed Embalmer No. 4830

P. O. Address Avon, 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.

10-21-63

11-4-63

Barber & ...