

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-040904

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 276 Primary Registration District No. 4410 Registrar's No. 47

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD.

AMENDED

Registration District No. 276
FILED NOV 4 1963

VS 300
Rev. 4/59

1 0810

2 0810

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4 0

5 1

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9 1201

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11

12 90-0

13 20

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. James</u>		Length of stay in 1b <u>40 yrs.</u>	c. CITY OR TOWN <u>St. James</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>216 Florine St.</u>
3. NAME OF DECEASED (Type or print) First <u>Chesney</u> Middle <u>B.</u> Last <u>John</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</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>Jan. 16 1924</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elec. Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (last birthday) <u>59</u>
13a. FATHER'S NAME <u>Robt. E. John</u>		13b. MOTHER'S MAIDEN NAME <u>Ramey John</u>	11. BIRTHPLACE (City and state or country) <u>Marion Co. Mo.</u>
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>-</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
14. NAME OF HUSBAND OR WIFE <u>CLARA JOHN</u>		17. INFORMANT <u>CLARA JOHN - 216 Florine St ST. JAMES, MO.</u>	
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>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</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>7-12-55</u> to <u>8-21-63</u> and last saw him alive on <u>8-21-63</u> Death occurred at <u>6 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. D. Tucker M.D.</u>		22b. ADDRESS <u>St James Mo</u>	22c. DATE SIGNED <u>10-29-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov. 1-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. JAMES, MO.</u>
24. FUNERAL DIRECTOR <u>Oral E. Gubler - St James, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 1 1963</u>	26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.

BY AFFIDAVIT OF

NOV 5 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 me Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oral E. Lickhiser

Licensed Embalmer No. 3546

P. O. Address St James

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.