

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042492

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 187

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

FILED NOV 12 1963

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Carroll	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall		c. CITY OR TOWN Carrollton	
Length of stay in 1b hours		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA-Fitzgibbon Hosp.		d. STREET ADDRESS (If outside, give location) 210 E. Second	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Alfred Middle Cecil Last Clay			4. DATE OF DEATH Month November Day 3 Year 1963			
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/27/36	9. AGE (last birthday) 27	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) L. LaBelle, Missouri		
12. CITIZEN OF WHAT COUNTRY U.S.A.						

13a. FATHER'S NAME William Washington		13b. MOTHER'S MAIDEN NAME Elsie Miller		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Betty Steverson, Carrollton, Mo Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound in chest		INTERVAL BETWEEN ONSET AND DEATH 20 min
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		
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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 12:05 a.m. Month, Day, Year Apr. 11/3/63					
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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.) 532 E. Washington St. Marshall, Saline Missouri	20f. CITY, TOWN, OR LOCATION Marshall, Saline Missouri	COUNTY	STATE
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21. I ~~attended the deceased from~~ **made an investigation 11/3/63** and last saw her/him alive on _____
 Death occurred at **12:36 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. L. Loukas</i> (Degree or title)	22b. ADDRESS Marshall Mo	22c. DATE SIGNED 11-3-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial & Re-	23b. DATE 11/3/63	23c. NAME OF CEMETERY OR CREMATORY LaBelle Missouri/Carrollton Missouri	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <i>Raymond L. Fulton</i> ADDRESS Mo.	25. DATE RECD. BY LOCAL REG. Nov. 3 - '63	26. REGISTRAR'S SIGNATURE <i>Cecil G. Reed</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ
 AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 USE BLACK INK OR TYPEWRITER RIBBON

1	VS 300
2	Rev. 4/59
3	
4	1925
5	0171
6	
7	2
8	0
9	0
10	8
11	
12	92-3
13	30

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 Joseph H. Green

Licensed Embalmer No. 4220

P. O. Address Fulton, Me.

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.