

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043154

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 543

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0168

2 8120

3

4 1

5 2

6

7 1

8 2

9 9030

10 20

11 812

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED DEC 8 1963

1. PLACE OF DEATH a. COUNTY <u>Cape</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Alexander</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		c. CITY OR TOWN <u>Mc Clure</u>	
Length of stay in lb <u>6 Weeks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>South E Missouri Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>Mc Clure</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eva Millisa White</u>			4. DATE OF DEATH Month Day Year <u>Nov 30 1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and state or country) <u>Jackson County, Illinois</u>
13a. FATHER'S NAME <u>No Record</u>		13b. MOTHER'S MAIDEN NAME <u>No Record</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>0-0-0</u>	
17. INFORMANT <u>John W White</u>		Address <u>Mrs Addie Chamness Olney, Illinois</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia Cardiac failure</u> DUE TO (b) <u>Subcapital fracture left femur</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) 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			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>Oct 19 - 1963</u> <u>Nov 30 - 1963</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fall in yard at home.</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>1:00 p.m. 10 19 63</u>	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>home</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>McClure Illinois</u>
21. I attended the deceased from <u>Oct 19 1963</u> to <u>Nov 30 1963</u> and last saw her/him alive on <u>Nov 30 1963</u> Death occurred at <u>8:35 pm Nov 30</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Thomas B. Ols M.D.</u>		22b. ADDRESS <u>Cape Girardeau Mo</u>	22c. DATE SIGNED <u>12/2/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec 2, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tower Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Murphyboro Illinois</u>
24. FUNERAL DIRECTOR <u>BRINKOFF-HOWELL</u>		25. DATE RECD. BY LOCAL REG. <u>12-3-63</u>	26. REGISTRAR'S SIGNATURE <u>James Rosten</u>

1966-100

STATEMENT BY LICENSED EMBALMER.

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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

Neil H. Kraushaar

Licensed Embalmer No. 4884

P. O. Address Cape Girardeau 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.