

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 1032

Primary Registration District No. 4042

Registrar's No. 88

STATE FILE NUMBER
63-046985

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 30 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>BOLLINGER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LUTESVILLE</u>		Length of stay in 1b <u>1 Mo.</u>	c. CITY OR TOWN <u>MARQUAND</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BOND NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u></u>

3. NAME OF DECEASED (Type or print) First <u>MATTIE</u> Middle <u>MAY</u> Last <u>BESS</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>19</u> Year <u>63</u>		
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5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</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>6-28-1875</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>BOLLINGER Co, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>FRANKLIN BERRY</u>	13b. MOTHER'S MAIDEN NAME <u>MARY C. BESS</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</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>NONE</u>	17. INFORMANT <u>C.P. BESS</u>	Address <u>MARQUAND, 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>Bronchial pneumonia</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral vascular hemorrhage</u>	<u>4 days</u>
	DUE TO (c) <u>Arterio sclerosis</u>	

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 <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 11-13-63 to 12-19-63 and last saw her alive on 12-19-63.
Death occurred at 12:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John Dugchais MD</u> (Degree or title)	22b. ADDRESS <u>Lutesville Mo.</u>	22c. DATE SIGNED <u>12-21-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-21-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>BOLLINGER Co, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>HOMAN FUNERAL HOME, MARQUAND, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12/27/63</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Buford Craden</u>
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BLACK INK OR TYPEWRITER RIBBON

JAN 7 1964

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 Edw. A. Graham

Licensed Embalmer No. 5195

P. O. Address Luttsville, Md.

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.