

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-047360

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 65 Primary Registration District No. 4113 Registrar's No. 55- STATE FILE NUMBER

DO NOT WRITE ON THIS STUB  
 AMENDED

**FILED JAN 6 1964**

|                     |              |       |
|---------------------|--------------|-------|
| VS 300<br>Rev. 4/59 | DATE AMENDED | 10210 |
| 20210               |              |       |
| 3                   |              |       |
| 4 1                 |              |       |
| 5 2                 |              |       |
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| 10                  |              |       |
| 11                  |              |       |
| 12 90-2             |              |       |
| 13 2-1              |              |       |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Chariton</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>Chariton</u>                       |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>City of Brunswick</u>  |   | Length of stay in 1b<br><u>one year</u>   | c. CITY OR TOWN <u>Brunswick</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                        |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (if outside, give location)<br><u>Brunswick</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Cora Bell Avery</u>   |   | 4. DATE OF DEATH<br>Month <u>Nov.</u> Day <u>13th</u> Year <u>1963</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug. 26 1867</u>   |
| 9. AGE (last birthday)<br><u>96</u>  |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HR<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>house wife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Illinois</u>  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.</u>  |
| 13a. FATHER'S NAME<br><u>Mosa Freeman</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>dont know</u>   |   |
| 14. NAME OF HUSBAND OR WIFE<br><u>Mosa Freeman</u>   |   | 17. INDEMNITY<br><u>Ida Bell Web</u><br>Address<br><u>Brunswick MO</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cebral hemorrhage</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertention</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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<br><u>Nov. 10th 63</u>   | COUNTY _____ STATE _____  |
| 21. I attended the deceased from <u>June 5th</u> to <u>Nov. 10th 63</u> and last saw her <u>alive</u> on <u>Nov. 10th 63</u><br>Death occurred at <u>Nov. 13th 63</u> <u>5PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |
| 22a. SIGNATURE<br><u>J. L. Peter</u> (Degree or title)   |   | 22b. ADDRESS<br><u>Brunswick MO</u>   |   |
| 22c. DATE SIGNED<br><u>Nov 14-63</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE<br><u>Nov. 15th</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Asbury</u>   |   |
| 23d. LOCATION (City, town, or county)<br><u>Keytesville Missouri</u>   |   |   |   |
| 24. FUNERAL DIRECTOR<br><u>Fremont Glasgow MO</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>Jan 2-1964</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Lovie Smith</u>   |

JAN 2 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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.