

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-048985**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 291

**FILED JAN 9 1964**

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
Rev. 4/59						
1 <u>0717</u>						
2 <u>1220</u>						
3						
4 <u>0</u>						
5 <u>1</u>						
6						
7 <u>0</u>						
8 <u>2</u>						
9 <u>331x</u>						
10						
11						
12 <u>1-0</u>						
13 <u>10</u>						
USE BLACK INK OR TYPEWRITER RIBBON	SHOULD READ					

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Length of stay in 1b <u>2 Weeks</u>	c. CITY OR TOWN <u>Salem</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Phelps Co. Mem. Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 5</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILFERD</u> Middle <u>MONROE</u> Last <u>HAPPEL</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</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>7/25/1898</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phelps Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>James Happel</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Adams</u>	
14. NAME OF HUSBAND OR WIFE <u>Lorene Rudd</u>		17. INFORMANT Address <u>Lorene Happel, Salem, Missouri</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   If yes, give war or dates of service <u>Yes</u>   <u>U.S.W. 2</u>		16. SOCIAL SECURITY NO. <u>73</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>cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</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) <u>Hypertension.</u>			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 checked="" 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>12-18-63</u> to <u>12-28-63</u> and last saw him alive on <u>12-28-63</u> Death occurred -at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E.E. Fink m.d.</u>		22b. ADDRESS <u>Rolla mo.</u>	22c. DATE SIGNED <u>12-28-63</u>
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/1/1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Salem, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Spencer Funeral Home, Salem, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-28-63</u>	26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>

01/01 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 Stephen E. Allison

Licensed Embalmer No. 5181

P. O. Address Salem, 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.