

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0005771

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 93 Primary Registration District No. 5345 Registrar's No. 64-13 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
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

MRFILED 06 64

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sac twp.</u>		Length of stay in 1b <u>16 yrs.</u>	c. CITY OR TOWN <u>Arcola</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>4 1/2 mi. E. of Arcola</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt #1; 4 1/2 mi. E.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Thomas White</u>			4. DATE OF DEATH Month Day Year <u>Feb. 22, 1964</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>5-5-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE (last birthday) <u>79</u> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Dade County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Benjamin Franklin White</u>		13b. MOTHER'S MAIDEN NAME <u>Mahalia Metlock</u>	14. NAME OF HUSBAND OR WIFE <u>Ora White</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>None</u>	17. INFORMANT Address <u>Mrs. Ora White; Rt #1, Arcola, Mo.</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>apoplexy</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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>7-1-63</u> to <u>2-22-64</u> and last saw him alive on <u>1-18-64</u> Death occurred at <u>9:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W.O. Cowan, M.D.</u>		22b. ADDRESS <u>Greenfield, Mo.</u>	22c. DATE SIGNED <u>2/24/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 24, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gum Springs Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Cedar County, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. C. Canada; Greenfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 24, 1964</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>

USE BLACK INK OR TYPEWRITER RIBBON
W.O. Cowan, M.D.

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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 J. C. Canada
Licensed Embalmer No. 4196

P. O. Address Greenfield, 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.