

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0014641

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Primary Registration District No. 3023 Registrar's No. 126

Registration District No.

Registrar's No.

VS 300  
Rev. 4/590425  
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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <i>Henry</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Henry</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Clinton</i>			Length of stay in lb <i>5-22-64</i>		
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <i>Clinton General Hosp.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>KATHERINE A HALSTED</i>			4. DATE OF DEATH Month Day Year <i>May 5 1964</i>		
5. SEX <i>Female</i> 6. COLOR OR RACE <i>white</i>			7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>			8. DATE OF BIRTH <i>5-16-1894</i> 9. AGE (last birthday) <i>69</i> 10. KIND OF BUSINESS OR INDUSTRY <i>None</i> 11. BIRTHPLACE (City and state or country) <i>Yankton S Dak. USA</i> 12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13a. FATHER'S NAME <i>Henry Paulson</i>			13b. MOTHER'S MAIDEN NAME <i>Mary Schultz</i> 14. NAME OF HUSBAND OR WIFE <i>Edwin Halsted</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>496-07-4188</i> 17. INFORMANT <i>Lone Olson</i> Address <i>Sioux City Iowa</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <i></i>			DUE TO (b) <i></i>		
			DUE TO (c) <i></i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes</i>			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 type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i></i>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.					
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	
21. I attended the deceased from <i>1960</i> to <i>5-5-64</i> and last saw <i>her</i> him alive on <i>5-5-64</i> Death occurred at <i>2 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Hugh B. Walker, MD</i> (Degree or title)		22b. ADDRESS <i>Clinton, Mo</i>		22c. DATE SIGNED <i>5-6-64</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 5-7-64</i>		23b. DATE <i>Englewood</i>		23c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) <i>Clinton Mo.</i>	
24. FUNERAL DIRECTOR <i>F.L. Schaberg Clinton Mo.</i>		ADDRESS <i>May 7, 1964</i>		25. DATE RECD. BY LOCAL REG. <i>Mildred Bigum</i> 26. REGISTRAR'S SIGNATURE	

(Licensed Embalmer's Statement on Reverse Side)

APR 10 1968

APR 20 1968

May 19 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 F. L. Schabes

Licensed Embalmer No. 4513

P. O. Address Clinton 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.