

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0018381

STATE FILE NUMBER

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 25

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 02.1
2 02.1
3
4 1
5 2
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7 0
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9 321x
10
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12 40-0
13 1-0

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				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Cedar</u>		Length of stay in 1b		a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u>		c. CITY OR TOWN <u>El Dorado Springs</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Springs</u>				d. STREET ADDRESS (If outside, give location) <u>317 S. Sumner</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>317 S. Sumner</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>317 S. Sumner</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	
			<u>Alice</u>	<u>Cornelia</u>	<u>Sheeks</u>	Month <u>May</u>	Day <u>11</u> Year <u>1964</u>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country)
<u>Female</u>	<u>White</u>		<u>1-1-1879</u>	<u>85</u>	<u>Housewife</u>		<u>Cedar Co., Mo.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housewife</u>				<u>Cedar Co., Mo.</u>		<u>U.S.A.</u>	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE	
<u>William Cook</u>			<u>Cornelia Hackleman</u>			<u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
<u>No</u>			<u>--</u>		<u>Mrs. G. Estes, El Dorado Spgs. 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>Cerebral vascular accident</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>generalized arteriosclerosis with cerebral arteriosclerosis</u>							
DUE TO (c)							
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 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	Hour	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>-0-</u> to <u>7:15 P</u> and last seen <u>alive</u> on <u>5/12/64</u>		Death occurred at <u>7:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Warley K. Stewart M.D.</u>				22b. ADDRESS <u>El Dorado Springs, Mo.</u>		22c. DATE SIGNED <u>5/12/64</u>	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>5-13-1964</u>	<u>Brush Creek Cemetery</u>		<u>Cedar Co. Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE			
<u>Gwinn-Carothers, El Dorado Spgs. Mo.</u>			<u>5/18/64</u>	<u>Hunter Swisher M.D.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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 Max W. Dickering

Licensed Embalmer No. 4696

P. O. Address El Dorado, 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.