

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0021856

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 85

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1080
2 20270
3
4 1
5 0
6
7 0
8 2
9 450.0
10
11
12 43-2
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JNF 10-EDQ2.64

1. PLACE OF DEATH a. COUNTY <u>Warrick</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u> Length of stay in 1b OR TOWN <u>4 days</u> <u>22 yrs 3 mths</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u> c. CITY OR TOWN <u>Pilot Grove</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>State Hospital No. 3</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jane (Egenia) Twenter</u>			4. DATE OF DEATH Month Day Year <u>May 25, 1964</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-1889</u>
9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cooper County Mo.</u>	11. BIRTHPLACE (City and state or country) <u>U. S.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13a. FATHER'S NAME <u>Theodore Twenter</u>		13b. MOTHER'S MAIDEN NAME <u>Coletta Neckermans</u>	
14. NAME OF HUSBAND OR WIFE <u>Hospital Records</u>		14. NAME OF HUSBAND OR WIFE <u>Hospital Records</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>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		17. INFORMANT <u>Hospital Records</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>Pneumonia</u> DUE TO (b) <u>Generalized 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) <u>Without Psychosis -- Mental Deficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Years</u>
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.) <u>Q</u>		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 <u>The Staff</u>		COUNTY STATE	
21. I attended the deceased from <u>February 21, 1942</u> to <u>May 25, 1964</u> and last saw her alive on <u>May 25, 1964</u> Death occurred at <u>9:40 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. <u>I viewed the remains.</u>			
22a. SIGNATURE <u>Jerry W. Glesner, M.D.</u> (Degree or title)		22b. ADDRESS <u>State Hospital No. 3</u>	
22c. DATE SIGNED <u>5-25-64</u>		22c. DATE SIGNED <u>5-25-64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>May 1964</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town, or county) <u>Pilot Grove, Mo.</u>	
24. FUNERAL DIRECTOR <u>Hays and Painter</u>		ADDRESS <u>Pilot Grove, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>5-29-64</u>		26. REGISTRAR'S SIGNATURE <u>Arma B. Jerry</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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 Larry S. Ireland

Licensed Embalmer No. 5052

P. O. Address Nevada 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.