

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 120 Primary Registration District No. 4194 Registrar's No. 38 STATE FILE NUMBER 38022707

UNFILED 1964

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>GENTRY</u>		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>GENTRY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ALBANY</u>		Length of stay in lb <u>40 days.</u>	c. CITY OR TOWN <u>STANBERRY</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>GENTRY Co. Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4th & ALANTHUS AVE.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLEOTA MAY MANN</u>			4. DATE OF DEATH Month Day Year <u>June 9, 1964</u>
5. SEX <u>FEMALE</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>3-10-1885</u>
9. AGE (last birthday) <u>78</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>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>STANBERRY, MO.</u>
12. CITIZENSHIP OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>V.S. CHILTON</u>	
13b. MOTHER'S MAIDEN NAME <u>EMMA BELL WILSON</u>		14. NAME OF HUSBAND OR WIFE <u>CHARLES B. MANN</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 <u>CHARLES B. MANN, STANBERRY, 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 thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH
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>malnutrition</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 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>April 1964</u> to <u>6/9/64</u> and last saw ^{her} alive on <u>6/9/64</u> Death occurred at <u>9:50 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Denise Parsons M.D.</u>		22b. ADDRESS <u>Albany Mo.</u>	22c. DATE SIGNED <u>6/12/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-11-64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HIGH RIDGE</u>	23d. LOCATION (City, town, or county) (State) <u>STANBERRY, MO.</u>
24. FUNERAL DIRECTOR <u>Johnson, F.H., STANBERRY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-15-64</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L.W. Bare</u>

USE BLACK INK OR TYPEWRITER RIBBON

Rec'd
6-15-'64

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 Lois Evans Johnson

Licensed Embalmer No. 4948

P. O. Address Stanberry, 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.