

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5-0026498

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

AGFILED 006 64

Registration District No. 4194

Primary Registration District No. 120

Registrar's No. \_\_\_\_\_

VS 300  
Rev. 4/59

1 0380

2 0380

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4 1

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7 0

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9 4341

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12 2-2

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 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>2 WKS.</u>		c. CITY OR TOWN <u>STANBERRY</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>GENTRY Co. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt 1, 1 mi. east of town</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>MYRTLE MAE ELEY</u>				4. DATE OF DEATH Month Day Year <u>JULY 30, 1964</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-1888</u>		9. AGE (last birthday) <u>76</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. 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>MAYSVILLE, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>HENRY SCHEPERS</u>				13b. MOTHER'S MAIDEN NAME <u>ADA BECKMAN</u>				14. NAME OF HUSBAND OR WIFE <u>BARTON DEO ELEY</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>RECORDS, JOHNSON F.H., 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>Acute Heart Failure (Congestion)</u>													
INTERVAL BETWEEN ONSET AND DEATH <u>76 hrs</u>													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (b) <u>Senility</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 checked="" 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>1 July 64</u> to <u>30 July 64</u> and last saw her alive on <u>7-30-64</u> Death occurred at <u>10:59 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Dr. D. Merrill DO</u> (Degree or title)				22b. ADDRESS <u>Albany Mo</u>				22c. DATE SIGNED <u>7-31-64</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>AUG 2, 1964</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HIGH RIDGE</u>		23d. LOCATION (City, town, or county) <u>STANBERRY</u>		23e. (State) <u>Mo.</u>					
24. FUNERAL DIRECTOR <u>JOHNSON F.H., STANBERRY, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>8-3-64</u>		26. REGISTRAR'S SIGNATURE <u>Mr. J. W. Bare</u>							

Permit issued 7-31-64

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 Charles Dean Albee

Licensed Embalmer No. 5238

P. O. Address Stanhurst, 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.