

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0044362

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 276

NV FILED 23 64

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u> Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Clinton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>HOSPITAL OR INSTITUTION</u> <u>Clinton Gen Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>607 N 4th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>C</u> Last <u>HARMEL</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>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>7-1-1900</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>4</u> Days <u>17</u> Hours <u>-</u> Min. <u>-</u>
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>None</u>		11. BIRTHPLACE (City and state or country) <u>Montrose Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>WM Reiling</u>		13b. MOTHER'S MAIDEN NAME <u>Eunice Conrad</u>	
14. NAME OF HUSBAND OR WIFE <u>Deceased</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>no</u>	
17. INFORMANT <u>Walter Markham</u>		Address <u>Clinton 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 hemorrhage</u> 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>None</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 <u>Clinton Mo.</u>		COUNTY <u>Clinton</u>		STATE <u>Mo.</u>	
21. I attended the deceased from <u>8-11-58</u> to <u>11-18-64</u> and last saw her alive on <u>11-17-68</u> Death occurred at <u>500 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>S. B. Hughes, M.D.</u>		22b. ADDRESS <u>Clinton Mo.</u>		22c. DATE SIGNED <u>11-19-64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>11/20/64</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Appleton City Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Appleton City Mo.</u>		24. FUNERAL DIRECTOR <u>Schaberg Funeral Home</u>		25. DATE RECEIVED BY LOCAL REG. <u>Nov. 19, 1964</u>	
26. REGISTRAR'S SIGNATURE <u>Walter Bigum</u>					

Clinton, Missouri

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.