

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

85-63-011368
STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 85

FILED MAR 18 1963

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1 0425					
2 0420					
3					
4 1					
5 2					
6					
7 0					
8 2					
9 174X					
10					
11					
12 2-2					
13 1-0					
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	SHOULD READ				
USE BLACK INK OR TYPEWRITER RIBBON					

1. PLACE OF DEATH a. COUNTY <u>Jenny</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		Length of stay in lb <u>172 days</u>	c. CITY OR TOWN <u>Calhoun</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR LOCATION (If NOT in hospital, give location) <u>Waldorf Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Sen. Delaney</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ALINE</u> Middle <u>E</u> Last <u>COMBS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>63</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>11-3-1913</u>
9. AGE (last birthday) <u>49</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u>	IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City, and state or country) <u>Deepwater Mo. U.S.A.</u>
13a. FATHER'S NAME <u>Jacob S. Meyer</u>		13b. MOTHER'S MAIDEN NAME <u>Edna J. Hurst</u>	
14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		16. SOCIAL SECURITY NO. <u>494 30-0733</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>		17. INFORMANT <u>Ray Combs</u> Address <u>Clinton Mo Rt. 3</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>Medullary Paralysis</u> DUE TO (b) <u>Uremia Obstructive</u> DUE TO (c) <u>Adenocarcinoma of uterus - metastasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 years</u>
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 <u>-</u> a.m. <u>-</u> 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>6-1-59</u> to <u>3-11-63</u> and last saw her/him alive on <u>3-11-63</u> Death: occurred at <u>4:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Clinton L. Glass</u> (Degree or title)		22b. ADDRESS <u>Clinton Mo.</u>	
22c. DATE SIGNED <u>3-11-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3-13-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calhoun</u>	23d. LOCATION (City, town, or county) (State) <u>Calhoun Mo.</u>
24. FUNERAL DIRECTOR <u>F.L. SCHABERG</u> ADDRESS <u>CLINTON, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>3-12-63</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

JUN 4 1963
MAR 20 1963

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Permit Obtained 3-12-63

(118)

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 F. L. Schaberg

Licensed Embalmer No. 4513

P. O. Address: Clinton 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.