

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015803

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 137 Primary Registration District No. 4216 Registrar's No. 138

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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94221

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Henry | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Henry | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Calhoun | | Length of stay in 'b' 25 yr,s | c. CITY OR TOWN Calhoun Mo |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Calhoun Mo | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Calhoun Mo |
| 3. NAME OF DECEASED (Type or print) First Amanda Middle Frances Last Little | | 4. DATE OF DEATH Month April Day 24 Year 1963 | |
| 5. SEX Female | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-25-1870 |
| 9. AGE (last birthday) 92 | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housekeeping | 11. BIRTHPLACE (City and state or country) Cole Camp Mo |
| 12. CITIZEN OF WHAT COUNTRY U S A | | 13a. FATHER'S NAME James H Williams | |
| 13b. MOTHER'S MAIDEN NAME Mary Ann England | | 14. NAME OF HUSBAND OR WIFE Lee B. Little | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Mr,s J A Honsey Calhoun Mo |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) Uremia 2 weeks |
| DUE TO (c) Myocardial Insufficiency 3 weeks | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Debilitation & Incontinence | | | 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>1-1-62</u> to <u>4-24-63</u> and last saw her him alive on <u>4-21-63</u> Death occurred at <u>10:50 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>Clinton L. Gray</i> | | 22b. ADDRESS <i>Calhoun Mo</i> | 22c. DATE SIGNED <i>4/25/63</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4-26-63 | 23c. NAME OF CEMETERY OR CREMATORY Calhoun Cem | 23d. LOCATION (City, town, or county) Calhoun Mo |
| 24. FUNERAL DIRECTOR Sickman & Dunning Clinton Mo | | 25. DATE RECD. BY LOCAL REG. 4-29-1963 | 26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i> |

USE BLACK INK OR TYPEWRITER RIBBON

0450
0450

Permit Obtained

1 2 0 21

4-29-63
Mr. Blaupf
cell when ready
M.B.

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 R. L. Dunning

Licensed Embalmer No. 4710

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.