

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035698

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 4191 Registrar's No. 96

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 15 1963

VS 300
Rev. 4/59

DATE AMENDED

1 03 70

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gasconade</u>		Length of stay in 1b <u>20 Yrs.</u>	c. CITY OR TOWN <u>Gasconade</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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BLUFFORD</u> Middle <u>E.</u> Last <u>JETT</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>9,</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. Married: <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	11. BIRTHPLACE (City and state or country) <u>Cooper Hill, Mo.</u>
13a. FATHER'S NAME <u>Wm. J. Jett</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Johns</u>	14. NAME OF HUSBAND OR WIFE <u>Pauline Isaac Jett</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. #1</u>		16. SOCIAL SECURITY NO. <u>495-24-7394</u>	17. INFORMANT Address <u>Mrs. Pauline Jett Gasconade, 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>Sudden death probably due to cardiac arrest</u>			INTERVAL BETWEEN ONSET AND DEATH <u>None</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)			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>5-16-51</u> to <u>10-9-63</u> and last saw her/him alive on <u>10-16-62</u> Death occurred at <u>5:30 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Carroll T. Shaw, M.D.</u>		22b. ADDRESS <u>Hermann, Missouri</u>	22c. DATE SIGNED <u>10-9-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-11-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gasconade Cemetery</u>	23d. LOCATION (City, town, or county) <u>Gasconade, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Herman Blumer, Inc.--Hermann, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>10-10-63</u>	26. REGISTRAR'S SIGNATURE <u>Delma Uffelman</u>

NOV 12 1963

OCT 31 1963

OCT 29 1963

DEC 4 1963

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 *Oswald Brown*

Licensed Embalmer No. 5187

P. O. Address Hermann, 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.