

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039672
STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 273

FILED OCT 28 1963

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED				
1 4 25					
2 0 4 25					
3					
4 17					
5 2					
6					
7 0					
8 2					
9 4 22					
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11					
12 9 6 2					
13 10					
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF				
ITEM NO.	SHOULD READ				
USE BLACK INK OR TYPEWRITER RIBBON	BY AFFIDAVIT OF				

1. PLACE OF DEATH a. COUNTY <u>Henry</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 Mo</u> Length of stay in 1b OR TOWN <u>3 YRS</u>		c. CITY OR TOWN <u>Clinton Mo</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 <u>G-BAR-H-Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Clinton Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Harvey Dukes</u>		4. DATE OF DEATH Month Day Year <u>October 21-1963</u>	
5. SEX <u>Male</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>5/20/1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Transfer & Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freight Line</u>	11. BIRTHPLACE (City and state or country) <u>Leesville Henry Mo</u>
13a. FATHER'S NAME <u>UNKNOWN</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 None</u>		17. INFORMANT <u>Bernard Dukes, Dentist</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>Pulmonary Edema</u> DUE TO (c) <u>Myocardial Insufficiency</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis - Seizure</u>			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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>1-1-1960</u> to <u>10-21-63</u> and last saw her/him alive on <u>10-21-63</u> Death occurred at <u>4:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Clinton L. Gandy D.O.</u>		22b. ADDRESS <u>Clinton Mo.</u>	
22c. DATE SIGNED <u>10/22/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Oct 23 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ferrywood</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>
24. FUNERAL DIRECTOR <u>F.L. Schenberg 814 S 2nd St Clinton Mo</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Biggers</u>	

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 Centerville

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.

Permit Obtained

10-23-63

(M.B.)