

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-042581**  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 88

**FILED OCT 28 1963**

VS 300  
Rev. 4/59

1 1050

2 1050

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12 86-2

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>			Length of stay in 1b <u>50 yrs</u>		c. CITY OR TOWN <u>Milan</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Coffman Nursing Home</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>none</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>A.</u> Last <u>Summers</u>				4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1963</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>5/3/1876</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </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>Hosewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Putnam County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>Zachariah Taylor Shearer</u>			13b. MOTHER'S MAIDEN NAME <u>Margrete A. Guffey</u>			14. NAME OF HUSBAND OR WIFE <u>Dec.</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>None</u>		17. INFORMANT <u>Mrs Ivan Knight</u> Address <u>Unicville, 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 vascular accident.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1962-</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Sensitivity</u>							<u>-</u>
DUE TO (c) <u>-</u>							<u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>-</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 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.) <u>-</u>			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year <u>  </u>		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.) <u>-</u>		20f. CITY, TOWN, OR LOCATION <u>-</u>		COUNTY <u>-</u>		STATE <u>-</u>	
21. I attended the deceased from <u>June 4, 1962</u> to <u>10-20-63</u> and last saw her alive on <u>10-20-63</u> Death occurred at <u>4:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. Simpson</u> (Degree or title)				22b. ADDRESS <u>Milan</u>		22c. DATE SIGNED <u>10-21-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/22/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>		23d. LOCATION (City, town, or county) (State) <u>Milan, Missouri</u>	
24. FUNERAL DIRECTOR <u>Schneiders</u> ADDRESS <u>Milan, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>10-24-63</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beckett</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 \_\_\_\_\_

*Geo. W. Savett*

Licensed Embalmer No. \_\_\_\_\_

*4799*

P. O. Address \_\_\_\_\_

*Milan, 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.