

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047798  
STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 335

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

1 0425

2 0425

3

4 1

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7 0

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9 1200

10

11

12 1-0

13 10

USE BLACK INK OR TYPEWRITER RIBBON

**FILED DEC 30 1963**

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Missouri b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		Length of stay in lb <u>1 week</u>	c. CITY OR TOWN <u>Clinton</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>Clinton Gen. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>301 S Orchard</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUNICE WAUGH JOHNSON</u>			4. DATE OF DEATH Month Day Year <u>12-23-63</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-1894</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>11 10 - -</u>	IF UNDER 24 HR Hours Min. <u>- -</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Henry Co. Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Dallas Beneyette</u>	
13b. MOTHER'S MAIDEN NAME <u>Nanny Mahler</u>		14. NAME OF HUSBAND OR WIFE <u>Geo. A Johnson</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>no</u>	17. INFORMANT <u>Geo. A Johnson</u> Address <u>Clinton 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>Hypostatic Pneumonia</u> DUE TO (b) <u>Interstitial Heart Disease</u> DUE TO (c) <u>with Decompensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>many days</u>
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 Month, Day, Year a.m. p.m.		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>12-18-63</u> to <u>12-23-63</u> and last saw her alive on <u>12-23-63</u> Death occurred at <u>7:00p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Richard N. King M.D.</u>		22b. ADDRESS <u>106 S. 3rd Clinton Mo</u>	
22c. DATE SIGNED <u>12-27-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-26-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u>		23d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>	
24. FUNERAL DIRECTOR <u>F.L. SCHABER</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 27, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>			

(Licensed Embalmer's Statement on Reverse Side)

FEB 11 1964

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. 4593

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.

Permit Obtained

12-27-63

(1963)