

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **863-047804**

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 343

FILED JAN 6 1964

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</u>		Length of stay in lb OR TOWN <u>14 days</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>Town + Country Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>501 S 3rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MERRY BELLE AVERY LIVINGSTON</u>			4. DATE OF DEATH Month Day Year <u>12 - 29 - 63</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>1-7-1872</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u> Hours <u>-</u> 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>Clinton mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James M Avery</u>		13b. MOTHER'S MAIDEN NAME <u>Sally Woodfolk</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</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>207 Lexington 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>Hepatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
DUE TO (b) <u>Chronic myocarditis and pericarditis 6 months</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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		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		

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 <u>Clinton</u>	COUNTY <u>mo</u>	STATE <u>mo</u>
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21. I attended the deceased from 12/27/63 to 12/29/63 and last saw her alive on 12/27/63
Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr. R.S. Hallingwood M.D.</u>		22b. ADDRESS <u>Clinton mo.</u>		22c. DATE SIGNED <u>1/4/64</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-31-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u>		23d. LOCATION (City, town, or county) <u>Clinton</u>

24. FUNERAL DIRECTOR <u>F.L. SCHABER</u>	ADDRESS <u>CLINTON, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>JAN. 4, 64</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF
 DOCUMENT
 MEDICAL CERTIFICATION
 USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59
 10425
 24225
 3
 4 1
 5 2
 6
 7 0
 8 2
 9 4/222
 10
 11
 12 86-0
 13 1-0

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 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 returned 1-4-64 (MB)