

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

**FILED 28 64**

Registration District No. 306 Primary Registration District No. 3042

Registrar's No. 99

STATE FILE NUMBER

**0041269**

VS 300  
Rev. 4/59

1 0621  
2 20620  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Madison</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Madison</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fredericktown Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>Marquand, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>404 E. College</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>Marquand, MO.</u>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Green</u> Last <u>Hale</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1964</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</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>8-16-1874</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Newton Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Green Hale</u>		13b. MOTHER'S MAIDEN NAME <u>Rosie Dudley</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)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Homer Hale</u>	17. ADDRESS <u>Fredericktown, 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>Probable carcinoma of colon</u> Interval between onset and death <u>Months</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>Feb 16, 1960</u> to <u>Oct 21, 1964</u> and last saw him alive on <u>Oct 18, 1964</u> Death occurred at <u>8:30</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Charles Michaeli MD</u>			22b. ADDRESS <u>Fredericktown, Missouri</u>		22c. DATE SIGNED <u>Oct 22, '64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-23-1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MARCUS MEMORIAL PARK</u>		23d. LOCATION (City, town, or county) (State) <u>Madison Co. MO.</u>		
24. FUNERAL DIRECTOR <u>Homan Funeral Home</u>		ADDRESS <u>Marquand, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>10-24-1964</u>	26. REGISTRAR'S SIGNATURE <u>Charles Broom, Jr. MD</u>		

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 Raymond B Wilson

Licensed Embalmer No. 4884

P. O. Address Greensboro, N.C.

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.