

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-030847
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 26

FILED AUG 25 1965

VS 300
Rev. 4/59

1 0101
2 0101
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4 1
5 2
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7 0
8 2
9 4201
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12 86-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>Centralia</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>Campbell House</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>117 S. Hickman</u>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Lou</u> Last <u>Gulick</u>			4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1965</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>12-28-1871</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</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>Homemaking</u>		11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>James T. White</u>		13b. MOTHER'S MAIDEN NAME <u>Louisa Catherine Robinson</u>	
14. NAME OF HUSBAND OR WIFE <u>George T. Gulick</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>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Mansil Sims, Sturgeon, 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>Acute myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 10 min</u>	
DUE TO (b) <u>Generalized Arteriosclerosis</u>		DUE TO (c) <u>9 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>old myocardial infarction</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 <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 <u></u> 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>8/16/65</u> , to <u></u> and last saw her <u>alive</u> on <u></u> . Death occurred at <u>11:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>William W. Bradley MD</u>			22b. ADDRESS <u>Centralia, Mo</u>		22c. DATE SIGNED <u>8/17/65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 19, 1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Perche Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sturgeon, Missouri</u>
24. FUNERAL DIRECTOR <u>Billy J. Madsen Centralia, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>Aug 18-1965</u>		26. REGISTRAR'S SIGNATURE <u>Maud McBride</u>

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

Permit issued Aug 18 - 1965 M.C.B.

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 Bill J. Meador

Licensed Embalmer No. 4876

P. O. Address Centralia, Missouri

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.