

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**65-035280**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 234

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>HENRY</b>		a. STATE <b>MISSOURI</b> COUNTY <b>HENRY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>CLINTON</b>		Length of stay in 1b <b>91 YEARS</b>	c. CITY OR TOWN <b>CLINTON</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>707 EAST JEFFERSON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>707 EAST JEFFERSON</b>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <b>CORA ETTA CRAIN</b>		Month Day Year <b>OCTOBER 7, 1965</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUC.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 6, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	9. AGE (last birthday) <b>91</b>
11a. BIRTHPLACE (City and state or country) <b>HENRY CO., MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>ANDREW JACKSON</b>		13b. MOTHER'S MAIDEN NAME <b>MARY S. COPPAGE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		17. INFORMANT <b>LUCILLE HETHERINGTON, CLINTON, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)			<b>Seconds</b>
DUE TO (b)			<b>minutes</b>
DUE TO (c)			<b>minutes</b>
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.
<b>Generalized Arteriosclerosis</b>			<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 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>1960</u> to <u>Oct. 7-65</u> and last saw her/him alive on <u>Oct 7-65</u> Death occurred at <u>1 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <i>Clinton L. Haspy</i>		22b. ADDRESS <i>Clinton, Mo.</i>	
22c. DATE SIGNED <i>10/8/65</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT. 9, 1965</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HICKORY GROVE</b>	23d. LOCATION (City, town, or county) <b>3 MILES EAST SHAWNEE MOUND</b>
24. FUNERAL DIRECTOR <b>SCHABERG-NICHOIS</b>		ADDRESS <b>CLINTON, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>Oct. 8, 1965</b>
26. REGISTRAR'S SIGNATURE <i>Mildred Begins</i>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 1 0425  
 2 0425  
 3  
 4 1  
 5 1  
 6  
 7 0  
 8 2  
 9 420.1  
 10  
 11  
 12 90-2  
 13 1-0  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 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 R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address K. C. Med

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 10-8-65 (M)