

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0033109
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 37 Primary Registration District No. 3023 Registrar's No. 257

FILED SEP 6 1966

VS 300
Rev. 4/59

1 0425
2 0420
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4 1
5 2
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7 0
8 2
9 2040
10
11
12 2-2
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		Length of stay in 1b <u>3 Days</u>	c. CITY OR TOWN <u>Deepwater</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>Wetzel Hospital</u>		Inst. Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie McAllister</u>		4. DATE OF DEATH Month Day Year <u>Sept 1-1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec-11-1881</u> 9. AGE (last birthday) <u>84</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
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>St Clair County, Mo. - S.A.</u>
13a. FATHER'S NAME <u>Robert Givens</u>		14. NAME OF HUSBAND OR WIFE <u>deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Givens Deepwater, Mo.</u>		Address	
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>Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
DUE TO (b) <u>Myocardial Insufficiency</u>			<u>3 days</u>
DUE TO (c) <u>Anemia due Lymphatic Leukemia</u>			<u>2 weeks</u>
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 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>2-1-65</u> to <u>9-1-66</u> and last saw her/him alive on <u>9-1-66</u>		Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>C. L. Glespy D.O.</u>		22b. ADDRESS <u>Clinton, Mo.</u>	22c. DATE SIGNED <u>9/2/66</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 3-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Appleton City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Appleton City Mo.</u>
24. FUNERAL DIRECTOR <u>Melvin JANSSENS, Deepwater</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 2-1966</u> 26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</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

Melvin L. Johnson

Licensed Embalmer No.

4529

P. O. Address

El Dorado Springs

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.