

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0040443

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 420

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. FILED NOV 3 1966		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Callaway</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>Callaway</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		c. CITY OR TOWN <u>Fulton</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Length of stay in 1b <u>39 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>Route # 1</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Memorial Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>Thomas</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1966</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1900</u>
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 <u>Agriculture</u>	9. AGE (last birthday) <u>66</u>
13a. FATHER'S NAME <u>Eli Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Letha May Parsons</u>	11. BIRTHPLACE (City and state or country) <u>Montgomery Co., Mo.</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>500-34-2846</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
14. NAME OF HUSBAND OR WIFE <u>Marjorie Brown</u>			17. INFORMANT Address <u>Marjorie Brown, Fulton, Mo.</u>
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) <u>Cerebral thrombosis</u>			<u>3 days</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>			<u>5 yrs</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) <u>Pulmonary Emphysema</u>			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>Oct. 27, 1966</u> to <u>Oct. 29, 1966</u> and last saw him alive on <u>Oct. 29, 1966</u> Death occurred at <u>11:50</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>Henry A. Sydow</u>		22b. ADDRESS <u>11a E. 5th St., Fulton, Mo.</u>	22c. DATE SIGNED <u>10-31-66</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-31-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Callaway Mem. Gdns.</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton, Mo.</u>
24. FUNERAL DIRECTOR <u>Maupin Funeral Home, Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-1-1966</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Carroll Cleveland</u>

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 Thomas M Emmons

Licensed Embalmer No. 5064

P. O. Address Fulton Md

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.