

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0049510

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 4218 Registrar's No. 358

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 3 1967

VS 300  
Rev. 4/59

10421

20421

3

4 1

5 0

6

7 1

8 2

9 171x

10

11

12 3-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Windsor</b>		Length of stay in 1b <b>18 days</b>	c. CITY OR TOWN <b>Windsor</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Windsor Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>400 S. Smith St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSIE (none) Heary</b>			4. DATE OF DEATH Month Day Year <b>December 24, 1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-1874</b>
9. AGE (last birthday) <b>92</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Circleville, Ohio</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>John Heary</b>	
13b. MOTHER'S MAIDEN NAME <b>Catherine Shupe</b>		14. NAME OF HUSBAND OR WIFE <b>(none)</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>		16. SOCIAL SECURITY NO. <b>(none)</b>	17. INFORMANT <b>Alice Sturman</b> Address <b>500 S. Franklin St. Windsor, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute terminal Cardio-Respiratory Collapse</b> DUE TO (b) <b>Hypertensive Abdominal Aneurysm</b> DUE TO (c) <b>Carcinoma of Cervix (Radium treated)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>3 hrs.</b> <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senility</b>			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 checked="" type="checkbox"/> NO <input 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 <b>10-15-58</b> to <b>Dec. 24, 66</b> and last saw her alive on <b>Dec. 24, 66</b> Death occurred at <b>5:50 A. M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Gardner M. Thurber, M.D.</b> (Degree or title)		22b. ADDRESS <b>Windsor, Mo.</b>	22c. DATE SIGNED <b>12-29-66</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-26-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Oak Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Windsor Mo.</b>
24. FUNERAL DIRECTOR <b>Clifford Gouge</b> ADDRESS <b>Windsor, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Dec. 29, 1966</b>	26. REGISTRAR'S SIGNATURE <b>Mildred Bigorn</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 Clifford George

Licensed Embalmer No. 5014

P. O. Address Windsor, 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.