

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0001342

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 4218 Registrar's No. 17

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0421

2 0510

3

4 1

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9/70X

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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

FILED JAN 18 1967

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Henry		a. STATE Mo	b. COUNTY Johnson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Windsor		c. CITY OR TOWN Lincoln	
Length of stay in 1b 11 weeks		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Windsor Hospital		d. STREET ADDRESS (If outside, give location) Route # 1	
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)			4. DATE OF DEATH		
First VIVIAN	Middle M.	Last CHASTAIN	Month January	Day 9,	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1913		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Johnson County, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME C. M. Williams		13b. MOTHER'S MAIDEN NAME Pearl Miller		14. NAME OF HUSBAND OR WIFE Bernice W. Chastain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Bernice Chastain Lincoln, Mo.
			Address R. # 1		

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) Circulatory collapse			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic Carcinoma DUE TO (c) Carcinoma of the breast			
			6 mos.
			30 mos.
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>12-29-66</u> , to <u>1-9-67</u> and last saw her ^{her} _{him} alive on <u>1-9-67</u> Death occurred at <u>1:45P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>William J. Smith MD</i>			22b. ADDRESS 103 W. Colt St. Windsor, Mo.		22c. DATE SIGNED 1/11/67
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/12/67	23c. NAME OF CEMETERY OR CREMATORY Laurel Oak Cemetery		23d. LOCATION (City, town, or county) (State) Windsor, Missouri
24. FUNERAL DIRECTOR ADDRESS Huston-Hadley Windsor, Missouri			25. DATE RECD. BY LOCAL REG. JAN. 13, 67	26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i>	

(Licensed Embalmer's Statement on Reverse Side)

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 Robert W. Kelley

Licensed Embalmer No. 5220

P. O. Address Windsor, Mo.

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.