

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0001370

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3023 Registrar's No. 18

FILED JAN 18 1967

VS 300
Rev. 4/59

0425
20420

3
4 1
5 1
6
7 0
8 2
976X

10
11
12 2-3
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fair View CLINTON</u>		Length of stay in 1b <u>30 yrs</u>	c. CITY OR TOWN <u>Deepwater R R # 2</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR # 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Enoise</u> Middle <u>F</u> Last <u>Landes</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1967</u>
5. SEX <u>female</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>Nov 16, 1913 53</u>
9. AGE (last birthday) <u>53</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	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>Hartwell, Mo</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Loyd Houk</u>	
13b. MOTHER'S MAIDEN NAME <u>Grace Harrington</u>		14. NAME OF HUSBAND OR WIFE <u>Ray</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.	17. INFORMANT <u>Ray Landes Deepwater, Mo</u>
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>Gun Shot Wound of Head</u> DUE TO (b) <u>with fracture of skull</u> DUE TO (c) <u>cranial hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>45 min</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 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>self inflicted wound 22 cal bullet</u>	
20c. TIME OF INJURY Hour <u>10</u> a.m. <u>PM</u> Month, Day, Year <u>1-12-67</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>At home</u>	20f. CITY, TOWN, OR LOCATION <u>RR #1 Deepwater</u>
20g. COUNTY <u>Henry</u>		20h. STATE <u>Mo</u>	
21. I attended the deceased from <u>Attached Dr Clause 1-12-67</u> and last saw her/him alive on _____ Death occurred at <u>10:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Richard H King M.D.</u>		(Degree or title) <u>Henry County coroner</u>	22b. ADDRESS <u>186 S. 3rd Clinton Mo</u>
22c. DATE SIGNED <u>1-13-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/15/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Teays Chapel</u>	23d. LOCATION (City, town, or county) <u>Henry County Mo</u>
24. FUNERAL DIRECTOR <u>Sickman-Dunning F H</u>		ADDRESS <u>Clinton, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>JAN. 13, 1967</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 R. L. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinton 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.

Permit obtained 1-13-69 (MB)