

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0019576

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 385

Primary Registration District No. 3038

Registrar's No. 118

FILED JUN 8 1967

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield		c. CITY OR TOWN Brookfield	
Length of stay in 1b 4 Days		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pershing Hospital		d. STREET ADDRESS (If outside, give location) 204 Market St.	
3. NAME OF DECEASED (Type or print) First Susie Middle Elizabeth Last Cassity		4. DATE OF DEATH Month May Day 29 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 4/26/1890
9. AGE (last birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY New Boston, Mo	
11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Balahm Stufflebean		13b. MOTHER'S MAIDEN NAME Lutie Clark	
14. NAME OF HUSBAND OR WIFE Albert Cassity		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.		17. INFORMANT Albert Cassity Address Brookfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO (b) Primary - carcinoma of cervix DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Weeks
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.	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 5-10-67 to 5-29-67 and last saw her him alive on 5-28-67 Death occurred at 430 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B O Howell (Degree or title) MD		22b. ADDRESS 125 E. LOCKLING AVE. Brookfield, Mo.	
22c. DATE SIGNED 5/29/67		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 5-31-1967		23c. NAME OF CEMETERY OR CREMATORY Park Lawn Memory Gardens	
23d. LOCATION (City, town, or county) Brookfield, Mo		24. FUNERAL DIRECTOR W. G. Baker ADDRESS Brookfield, Mo	
25. DATE RECD. BY LOCAL REG. 5-29-67		26. REGISTRAR'S SIGNATURE Anna Watson	

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

[Handwritten Signature]

Licensed Embalmer No. 4822

P. O. Address

[Handwritten Address]

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.