

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031818

STATE FILE NUMBER

AMENDED

Registration District No. 27 Primary Registration District No. 4031 Registrar's No. 109

FILED SEP 22 1961

1. PLACE OF DEATH a. COUNTY Bates		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Bates	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Adrian		Length of stay in 1b 12 Yrs.	c. CITY OR TOWN Adrian Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Rufus Middle R. Last Otwell			4. DATE OF DEATH Month August Day 26 Year 1961		
5. SEX Male	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 7-8-73	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Linn, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Watson T. Otwell		13b. MOTHER'S MAIDEN NAME Mary E. maline Welb		14. NAME OF HUSBAND OR WIFE Mary Otwell	
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. No		17. INFORMANT Address A.E. Irvin, Adrian, Mo.	

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) Coronary Thrombosis			30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Anterior Sclerosis		5 yrs
	DUE TO (c)		

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		
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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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Mar 18 1943 to Aug 25 1961 and last saw ^{her}him alive on Aug 25 1961
Death occurred at 1 AM Aug 26 1961 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) D. S. Colson Do	22b. ADDRESS Adrian Mo	22c. DATE SIGNED Aug 28 1961
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-28-61	23c. NAME OF CEMETERY OR CREMATORY Crescent Hill Cem.	23d. LOCATION (City, town, or county) Adrian, Mo.
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24. FUNERAL DIRECTOR ADDRESS Six Funeral Service, Adrian, Mo.	25. DATE RECD. BY LOCAL REG. Aug 28-1961	26. REGISTRAR'S SIGNATURE Kendall Perry
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1931

DEPARTMENT OF HEALTH

name of decedent

residence

date

place

cause of death

diagnosis

sex

age

occupation

color

height

education

weight

marital status

disability

insurance

other remarks

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,

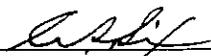
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 3650

P. O. Address Adrian, 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.

DEPARTMENT OF HEALTH

STATE OF MISSOURI