ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-036705
STATE FILE NUMBER

AMENDED

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 66

FILED OCT 30 1961

1. PLACE OF DEATH
a. COUNTY: HOLT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: MOUND City
Length of stay in 1b: 9 YEARS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION:
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: HOLT
c. CITY OR TOWN: MOUND City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location):
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle Last ERWIN
4. DATE OF DEATH: Month Oct Day 25 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-27-1883
9. AGE (last birthday): 78
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and state or country): HOLT COUNTY, MO
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: GOULDMAN ERWIN
13b. MOTHER'S MAIDEN NAME: MARGARET ANN MEEK
14. NAME OF HUSBAND OR WIFE: ZULA MAY ERWIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. ZULA ERWIN Address: MOUND City, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute Congestive
DUE TO (b): Heart failure
DUE TO (c):
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Oct 24-61, to Oct 25-61 and last saw ~~her~~ him alive on Oct 25-61
Death occurred at 11 a m m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: D B Perry (Degree or title) M.D.
22b. ADDRESS: Mound City Mo
22c. DATE SIGNED: 10-26-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10-27-1961
23c. NAME OF CEMETERY OR CREMATORY: CATON CEMETERY
23d. LOCATION (City, town, or county) (State): HOLT COUNTY, Mo.
24. FUNERAL DIRECTOR ADDRESS: JAMES H. CRAWFORD, MOUND City, Mo.
25. DATE RECD. BY LOCAL REG.: 10-26-1961
26. REGISTRAR'S SIGNATURE: James H Crawford

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | DOCUMENT
SHOULD READ | BY AFFIDAVIT OF
ITEM NO.

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 James H Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City

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.