

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040053

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Reg. No. 11 Primary Registration District No. 4024 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY <b>BARRY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ARK.</b> b. COUNTY <b>BOONE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CASSVILLE</b>		Length of stay in 1b <b>hrs.</b>	c. CITY OR TOWN <b>HARRISON</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>104 W. 17th. ST?</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>NORTH PINE STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE OLIVER MOUNT</b>			4. DATE OF DEATH Month Day Year <b>11 23 61</b>			
--	--	--	---	--	--	--

5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/8/93</b>	9. AGE (last birthday) <b>68</b>	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) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Marion, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	--	---	---

13a. FATHER'S NAME <b>Wilber S. Mount</b>	13b. MOTHER'S MAIDEN NAME <b>Heneritta Roetramell</b>	14. NAME OF HUSBAND OR WIFE <b>Elsie M. Mount</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>unkown</b>	17. INFORMANT Address <b>J. W. Mount, 104 W.17th., Cassville</b>
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>apparent heart attack</b>		INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
--	--	--

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  
DUE TO (b) **(History of heart condition for some 4 to 5 years)**  
DUE TO **Investigated by: Doyle E. Williams, Coroner Boone Co. Mo**

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 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 <b>HARRISON</b>	COUNTY <b>BOONE</b>	STATE <b>ARK.</b>
--	--	---	------------------------	----------------------

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at **1:30 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Grace Williams, Local Registrar</b>	22b. ADDRESS <b>Cassville Mo</b>	22c. DATE SIGNED <b>11-24-61</b>
--	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/25/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Harrison, Ark.</b>
--	------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <b>Doyle E. Williams, Cassville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-24-61</b>	26. REGISTRAR'S SIGNATURE <b>Grace Williams</b>
--	---	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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

*Daryl E. Williamson*

Licensed Embalmer No. 4883

P. O. Address Cassville

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.