

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040466

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Filed for Registration District No. 3015 Registrar's No. 122  
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AMENDED

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clinton</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cameron</u>		Length of stay in 1b <u>Life Time</u>	c. CITY OR TOWN <u>Cameron</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Third St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>West Third St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie Mae</u> Middle <u>Cline</u> Last <u>Cline</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1961</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-1884</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS, OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and state or country) <u>Clinton Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Wm. Talbott</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Mae Aldrich</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>			17. INFORMANT <u>Catherine Byers Cameron Mo</u>		
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) <u>Sepsis</u>					<u>1 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Decubital cellulitis caused by prolonged recumbency</u>					<u>6 months</u>
DUE TO (c) <u>Arteriosclerosis and cerebral hemiplegia</u>					<u>36 months</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 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>					
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 <u>6-10-58</u> to <u>11-30-61</u> and last saw her/him alive on <u>11-29-61</u> Death occurred at <u>3:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>[Signature]</u>			22b. ADDRESS <u>Cameron Mo</u>		22c. DATE SIGNED <u>12-7-61</u>
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	23b. DATE <u>Dec. 2-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cameron Mo</u>		
24. FUNERAL DIRECTOR <u>Poland Funeral Home</u>		ADDRESS <u>Cameron Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-3-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Robert F. Palou

Licensed Embalmer No. 4777  
222 West 2th  
P. O. Address Camden Pa

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.