

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045973

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 514

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

FILED JAN 5 1962

1. PLACE OF DEATH
 a. COUNTY ST FRANCOIS
 b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Farmington Length of stay in 1b _____
 c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 604 N 'A' St. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MISSOURI b. COUNTY ST FRANCOIS
 c. CITY OR TOWN FARMINGTON Inside Limits Yes No
 d. STREET ADDRESS (if outside, give location) 604 N 'A' St. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
BILL DEFOREST
 4. DATE OF DEATH Month Day Year
DEC. 29 1961

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 3/30/07 9. AGE (last birthday) 54 IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life or if retired) OIL BUS. DRIVER 10b. KIND OF BUSINESS OR INDUSTRY OIL BUS. DR. 11. BIRTHPLACE (City and state or country) LICKING MO. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME WILLIAM E DEFOREST 13b. MOTHER'S MAIDEN NAME IRENE TRUSTY 14. NAME OF HUSBAND OR WIFE GOLDA MCCLARD DEFOREST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Address MRS BILL DEFOREST FARMINGTON 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) Acute hemorrhagic Pancreatitis INTERVAL BETWEEN ONSET AND DEATH 3 day
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
 DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. Chronic cholelithiasis & Cholecystitis
 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 Dec 27, 1961 to Dec 29, 1961 and last saw him alive on Dec 28, 1961
 Death occurred at 6 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. A. Huckstep MD 22b. ADDRESS Farmington, Mo 22c. DATE SIGNED 12/30/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 12/31/61 23c. NAME OF CEMETERY OR CREMATORY Hillview Memo. Gardens 23d. LOCATION (City, town, or county) (State) FARMINGTON MISSOURI

24. FUNERAL DIRECTOR ADDRESS C. H. COZEAN FARMINGTON MO. 25. DATE RECD. BY LOCAL REG. Dec. 30, 1961 26. REGISTRAR'S SIGNATURE Eather Rudloff

FEB 2 1962

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 _____

C. H. Cozen

Licensed Embalmer No. _____

4084

P. O. Address _____

Jamington

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.