

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-047637

STATE FILE NUMBER

AMENDED	Registration District No. <u>373</u>	Primary Registration District No. <u>4545</u>	Registrar's No. <u>3</u>			
DATE AMENDED	1. PLACE OF DEATH a. COUNTY <u>Webster</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>			
	b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshfield</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Marshfield</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>431 S. Olive</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>431 S. Olive</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
	3. NAME OF DECEASED (Type or print) First <u>AUGUSTA</u> Middle <u>BELLE</u> Last <u>CAUGHRAN</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1961</u>		
	5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>8/23/88</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u>
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Webster Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
	13a. FATHER'S NAME <u>David R. Good</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Turner</u>		14. NAME OF HUSBAND OR WIFE <u>David A. Caughran</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>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Edith Jarrett; Marshfield, Mo.</u>		
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Over 10 years</u>
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>					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>1940</u> , to <u>Dec. 31, 1961</u> and last saw her/him alive on <u>Dec. 31, 1961</u> Death occurred at <u>10:30</u> p. <u>    </u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>C.R. Macdonnell M.D.</u> (Degree or title)			22b. ADDRESS <u>Marshfield, Mo.</u>		22c. DATE SIGNED <u>1/2/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-4-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Marshfield, Mo.</u>		
24. FUNERAL DIRECTOR <u>Ayre-Goodwin</u>		ADDRESS <u>Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-3-62</u>	26. REGISTRAR'S SIGNATURE <u>J. Francis</u>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

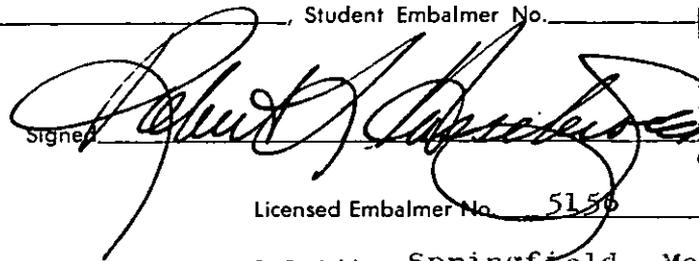
JAN 9 1962

**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



Licensed Embalmer No. 5156

P. O. Address Springfield, 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.