MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-000949
STATE FILE NUMBER

AMENDED

FILED JAN 24 1962

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY Dent
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Spring Creek TWP — Length of stay in 1b: 1 yr
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Spring Creek TWP, Salem, Mo. — Inside Limits: Yes ☐ No ☒

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

3. NAME OF DECEASED (Type or print) First: Martha Middle: Ellen Last: Plank
4. DATE OF DEATH Month: January Day: 16 Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: March 20, 1876
9. AGE (last birthday): 82 — 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): House wife
10b. KIND OF BUSINESS OR INDUSTRY: House keeping
11. BIRTHPLACE (City and state or country): Dent County
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Jim Blake
13b. MOTHER'S MAIDEN NAME: Elizabeth, McGuire
14. NAME OF HUSBAND OR WIFE: Will Plank
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): X
16. SOCIAL SECURITY NO.: X
17. INFORMANT: Anna Hamm — Address: Salem, Missouri

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 5 yrs.
DUE TO (c) _____
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 12-28-60, to 12-8-61 and last saw her/him alive on 12-8-61
Death occurred at 5:15 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title)
22b. ADDRESS Salem, Mo.
22c. DATE SIGNED 1-19-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE 1-18-1962
23c. NAME OF CEMETERY OR CREMATORY North Lawn Memoiral Cem.
23d. LOCATION (City, town, or county) (State): Salem, Missouri
24. FUNERAL DIRECTOR: SPENCER FUNERAL HOME INC. ADDRESS: SALEM, MO.
25. DATE RECD. BY LOCAL REG.: 1/18/62
26. REGISTRAR'S SIGNATURE: M. M. Hart, M.D. by Am

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.