

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008405

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District **1003** Registrar's No. **1729**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 16 1962

VS 300
Rev. 4/59

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2/10/62

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1286-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>											
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Hamilton Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH		Month Day Year											
Laura						McClary				February		9, 1962											
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR											
Female		White				8/14/1878		83		Months Days		Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY											
Housewife				At Home				Caledonia, Mo.				U.S.A.											
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
Joseph Baker				Margaret Plummer				Robert															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address											
No.				None				Ruth Tathbun, 7300 Melrose.															
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)												Several days											
DUE TO (b)																							
DUE TO (c)												493x											
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.											
Generalized Arteriosclerosis + Chronic Brain Syndrome												<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		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 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				COUNTY STATE											
21. I attended the deceased from <u>Dec. 5, 1961</u> to <u>Feb 9, 1962</u> and last saw her alive on <u>Feb 8, 1962</u>																							
Death occurred at <u>1:50 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED											
<u>A. F. Montgomery, M.D.</u>						<u>110 S. Central Ave Clayton</u>						<u>2/10/62</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)											
Removal				2-11-62				Local				Caledonia, Mo.											
24. FUNERAL DIRECTOR						ADDRESS						25. DATE RECD. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE					
Albert H. Hoppe Inc.,						4700 Washington,						Blvd. FEB 10 1962						<u>Earl Smith, M.D.</u>					

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 Stanley H. Flexon

Licensed Embalmer No. 14193

P. O. Address St Louis

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.