

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010033

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. \_\_\_\_\_ Registrar's No. 367

**FILED APR 9 1962**

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Agency Twsp</u>		Length of stay in 1b <u>80yrs</u>	c. CITY OR TOWN <u>Agency</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Agency</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle _____ Last <u>Wright</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1962</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>Feb 22, 1877</u>	9. AGE (last birthday) <u>84</u>	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) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Agency Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Tom Copple</u>	13b. MOTHER'S MAIDEN NAME <u>Rachel Garren</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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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>Joseph, Wright, Agency Mo</u> Address _____
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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>Arteriosclerotic Heart Disease</u>		<u>Ukn.</u>
DUE TO (b) <u>Hypertension</u>		<u>Ukn.</u>
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 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 _____
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21. I attended the deceased from <u>10/17/60</u> to <u>2/15/62</u> and last saw her <u>hsp</u> alive on <u>1/18/62</u> Death occurred at <u>2 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Doctor or title) <u>Charles H. Bascom MD</u>	22b. ADDRESS <u>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</u>	22c. DATE SIGNED <u>2/17/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/17/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Agency Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Agency Mo</u>
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24. FUNERAL DIRECTOR <u>John Stupp</u> ADDRESS <u>St. Joseph, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>April 2, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Clark Handell</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF C.H. Bascom, M.D.

VS 300 Rev. 4/59  
15110  
25110  
3  
4 1  
5 2  
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7 0  
8 1  
9444 X  
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11  
12 90-0  
13 1-1

**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,

~~\_\_\_\_\_~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*John E. Rupp*

Licensed Embalmer No. \_\_\_\_\_

*3986*

P. O. Address \_\_\_\_\_

*H. Joseph. 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.