

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010363

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 32

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 26 1962

1. PLACE OF DEATH a. COUNTY <b>Dent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Salem</b>		Length of stay in 1b <b>10 yrs</b>	c. CITY OR TOWN <b>Salem</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>West F Ave</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>West F Ave</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sylvia Jane Herndon</b>			4. DATE OF DEATH Month Day Year <b>March 20 1962</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-03</b>
9. AGE (last birthday) <b>58</b>		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) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>x</b>	11. BIRTHPLACE (City and state or country) <b>Dent Co Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13a. FATHER'S NAME <b>James T Nevins</b>	
13b. MOTHER'S MAIDEN NAME <b>Amy Capp</b>		14. NAME OF HUSBAND OR WIFE <b>xx</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>x</b>	17. INFORMANT <b>Mrs Kenneth Spencer Salem Mo</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
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 (a) <b>Chronic pulmonary emphysema-polycythemia</b>			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.) <b>no</b>	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
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 <b>11-16-57</b> to <b>3-20-62</b> and last saw her alive on <b>3-20-62</b> Death occurred <b>11:20 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>L.H. Hunt M.D.</b> (Degree or title)		22b. ADDRESS <b>Salem, Missouri</b>	22c. DATE SIGNED <b>3-23-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Mar 23-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miner Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Dent Co Missouri</b>
24. FUNERAL DIRECTOR <b>Spencer Funeral Home Inc</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>3/23/62</b>	26. REGISTRAR'S SIGNATURE <b>M. M. Clark, M.D. by Ann</b>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300  
Rev. 4/59  
10331  
20331  
3  
4 1  
5 3  
6  
7 0  
8 2  
9 4222  
10  
11  
12 90-0  
13 1-0

DATE AMENDED

**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

*Donald J. Palmer*

Licensed Embalmer No.

9374

P. O. Address

*Palmer*

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.