

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-012381

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 116

STATE FILE NUMBER

FILED MAR 27 1962					
1. PLACE OF DEATH a. COUNTY <u>ST. FRANCIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FARMINGTON, MO.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SUNSET NURSING HOME.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MADISON</u> c. CITY OR TOWN <u>MAROUAND, MO.</u> 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 First <u>IDA</u> Middle <u>E.</u> Last <u>BREEN</u>			4. DATE OF DEATH Month <u>MAR</u> Day <u>14</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>AUG 16, 1884</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE-WIFE</u>		11. BIRTHPLACE (City and state or country) <u>MAROUAND, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>WILLIS ASLINKER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY MILLER</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM GREEN</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 Address <u>MR. LECIL GREEN ST. LOUIS, 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>Cerebral Oxygation</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> DUE TO (b) <u>Thrombosis cerebral vessel</u> <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis</u> 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					
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 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
21. I attended the deceased from <u>Mar 3, 1962</u> to <u>Mar 14, 1962</u> and last saw him alive on <u>Mar 14, 1962</u> Death occurred at <u>5:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>Farmington, Mo</u>		22c. DATE SIGNED <u>3/16/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-17-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rhodes Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>MAROUAND MISSOURI</u>	
24. FUNERAL DIRECTOR <u>R. Caldwell & Sons</u> ADDRESS <u>Flat River</u>		25. DATE RECD. BY LOCAL REG. <u>Mar. 16, 1962</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 1 0945
 2 0620
 3
 4 1
 5 2
 6
 7 0
 8 2
 9 332X
 10
 11
 12 86-2
 13 1-0
 INSTEAD OF
 DOCUMENT
 SHOULD READ
 BY AFFIDAVIT OF
 USE BLACK INK OR TYPEWRITER RIBBON

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 Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River 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.