

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2805-62-012594
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2805

FILED MAR 26 1962

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Rev. 4/59

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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

| | | | | | | | | | | | |
|--|--|---|-------------------|---|--|--|--|--|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>11 Days Last time</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Bourban</u> | | c. CITY OR TOWN <u>Ft. Scott</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Frisco Employees Hospital Assn</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (IF outside, give location) <u>820 E. Wall</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles McKinley Doane</u> | | | First Middle Last | | | 4. DATE OF DEATH <u>March 12, 1962</u> | | | Month Day Year | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 1st, 1894</u> | | 9. AGE (last birthday) <u>67 yrs</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Foreman-retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | | 11. BIRTHPLACE (City and state or country) <u>Butler, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | | | |
| 13a. FATHER'S NAME <u>Wm. C. Doane</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Maggie Shuster</u> | | 14. NAME OF HUSBAND OR WIFE <u>Alberta Billman</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War 2</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Wife Same Address</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>Carcinoma of Small Bowel</u> <u>with obstruction</u> <u>metastasis from Carcinoma of cecum</u> DUE TO (b) <u>153.0</u> DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>known</u> <u>Dec 1960</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 type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>3-1-62</u> to <u>3-12-62</u> and last saw him alive on <u>3-12-62</u> Death occurred at <u>7:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Norman Miller MD</u> | | | | | | 22b. ADDRESS <u>4960 Laclede Ave.</u> | | | 22c. DATE SIGNED <u>3-12-62</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>3-13-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) <u>Fort Scott, Kansas</u> | | 23e. (State) <u>Kansas</u> | | | |
| 24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u> | | | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>MAR 13 1962</u> | | 26. REGISTRAR'S SIGNATURE <u>Roan Smith. 17. D.</u> | |

USE BLACK INK
OR
TYPEWRITER RIBBON

MAR 27 1962

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 Harvey Stahl

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.