

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-015922

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 384 Primary Registration District No. 8099 Registrar's No. 70

FILED APR 17 1962

VS 300
Rev. 4/59

1 0585
2 0210
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4 1
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7 0
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9 331X
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12 86-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>hinn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CHARITON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Length of stay in 1b <u>45 days</u>	c. CITY OR TOWN <u>Mendon - 2 mi SE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u> <u>LOUISE CONVALESCENCE</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 type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CORNELIA</u> Middle <u>MARNER</u> Last <u>MARNER</u>			4. DATE OF DEATH Month <u>4</u> - Day <u>9</u> - Year <u>1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>4/17/1898</u>
9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>	11. BIRTHPLACE (City and state or country) <u>BRUNSWICK MO</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JAMES G. JEFFRESS</u>	
13b. MOTHER'S MAIDEN NAME <u>NORA J. BYLE</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN S. MARNER</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. <input checked="" type="checkbox"/>	
17. INFORMANT <u>MRS. Sheslie LITRELL Mendon MO</u>		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) <u>Murder</u> DUE TO (b) <u>Carbine wound accident</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>3 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac</u>			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.) <u></u>	
20c. TIME OF INJURY Hour <u></u> s.m. <u></u> p.m. <u></u>			
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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>
20f. STATE <u></u>			
21. attended the deceased from <u>Nov. 17 1961</u> to <u>4-9-62</u> and last saw her alive on <u>4-9-62</u> Death occurred at <u>7</u> <u>P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. W. Burkhardt MD</u> (Degree or title)		22b. ADDRESS <u>Brookfield MO</u>	22c. DATE SIGNED <u>4/10/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/11/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mendon</u>	23d. LOCATION (City, town, or county) (State) <u>Mendon MO</u>
24. FUNERAL DIRECTOR <u>S. L. Shepard</u>		25. DATE RECD. BY LOCAL REG. <u>4-11-62</u>	26. REGISTRAR'S SIGNATURE <u>Anna Watson</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 Billie C. Gonder

Licensed Embalmer No. 4980

P. O. Address Mendon, 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.