

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-018035  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 298

**FILED MAY 28 1962**

VS 300  
Rev. 4/59

10109  
206901

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4 0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Monroe</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Paris.</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>University of Missouri Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Brown</u> Last <u>Threlkeld</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1962</u>	
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>1-5-18</u>
9. AGE (last birthday) <u>44</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</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>Farmer</u>		10b. <del>INDUSTRY</del> <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Paris, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>William A. Threlkeld</u>	
13b. MOTHER'S MAIDEN NAME <u>Ruby Brown</u>		14. NAME OF HUSBAND OR WIFE <u>B. Nadine Threlkeld</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Medical Records</u>		Address <u>Columbia, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia; intercapillary glomerulo-</u> <u>DIABETES MELLITUS</u> sclerosis DUE TO (b) <u>20 yrs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Congestive Heart Failure; Hypertensive Ht Disease</u>		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.) <u>Diagnosis</u>	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <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> STATE <u></u>	
21. I attended the deceased from <u>5/22/62</u> to <u>5/25/62</u> and last saw <u>her</u> alive on <u>5/25/62</u> Death occurred at <u>5:55 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Thomas W. Burns, M.D.</u> (Degree or title)		22b. ADDRESS <u>1009 So. Providence Rd</u>	
22c. DATE SIGNED <u>5/25/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5/27/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u>
24. FUNERAL DIRECTOR <u>E.H. AGNEW</u> ADDRESS <u>Paris, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 25 1962</u>	
		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

USE BLACK INK OR TYPEWRITER RIBBON

JUN 5 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 E. Magnew

Licensed Embalmer No. 4000

P. O. Address Paris, 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.