

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018060

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 570

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 28 1962

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in 1b <u>1 Mo.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 2</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>Missouri</u> b. COUNTY <u>Putnam</u> c. CITY OR TOWN <u>Unionville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R. R. #3</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>B</u> Last <u>BUSTER</u>	4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1962</u>
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5. SEX <u>Female</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. 1882</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Sullivan City, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>Harry Rouse</u>	13b. MOTHER'S MAIDEN NAME <u>Liza</u>	14. NAME OF HUSBAND OR WIFE <u>Tom Buster</u>
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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>David Fowler (Sheriff) Unionville, Mo.</u>
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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>Arteriosclerotic Heart disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Chronic Brain Syndrome</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
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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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. / p.m. Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from May 18, 1962 to May 19, 1962 and last saw her alive on May 18, 1962
 Death occurred at 5:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>William T. Tabor M.D.</i>	22b. ADDRESS <u>State Hospital No. 2</u>	22c. DATE SIGNED <u>5/19/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5/19/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u> </u>	23d. LOCATION (City, town, or county) (State) <u>Unionville Missouri</u>
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25. DATE RECD. BY LOCAL REG. <u>May 19, 1962</u>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Handell</i>
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Thomas Funeral Home St. Joseph, Mo.
N.A.S.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF
M. Tabor, M.D.
 MEDICAL CERTIFICATION
 SHOULD READ
 ITEM NO.

VS 300 Rev. 4/59
 15117
 20860
 3
 4 1
 5 1
 6
 7 C
 8 O
 94200
 10
 11
 12 93-C
 13 1-0

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 Charles E Bennett

Licensed Embalmer No. 4697

P. O. Address St Joseph 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.