

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-022132

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 857

FILED JUL 2 1962

VS 300
Rev. 4/59

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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 BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CARTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 1 DAY	c. CITY OR TOWN VAN BUREN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) PO BOX, 65
3. NAME OF DECEASED (Type or print) First SAMUEL Middle FREDERICK Last FARRIS		4. DATE OF DEATH Month JUNE Day 14 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-20-96
9. AGE (last birthday) 66		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) CARTER CO. MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JAMES P. FARRIS	
13b. MOTHER'S MAIDEN NAME FLORENCE E. HAMPTON		14. NAME OF HUSBAND OR WIFE MARTHA FARRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. _____	
17. INFORMANT VA. HOSPITAL, RECORDS. POPLAR BLUFF, MO.		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM UNSPECIFIED CEREBRAL ARTERY DUE TO (b) HYPERTENSIVE VASCULAR DISEASE DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 8 HOURS 1 or 2 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) BRONCHITIS, A STHMATIC			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 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 7:52 AM on JUNE 14, 1962 to JUNE 14, 1962 and last saw him on JUNE 14, 1962 . Death occurred at 7:52 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert S. Cohen</i> ROBERT S. COHEN M.D. CHIEF MED SVC.		22b. ADDRESS VA. HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 6-15-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-18-62	23c. NAME OF CEMETERY OR CREMATORY Van Buren Cemetery Van Buren MO	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR McSpadden	ADDRESS Van Buren, Mo.	25. DATE RECD. BY LOCAL REG. 6/26/1962	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>

VS JUL 3 1962

JUL 18 1962

MAY 24 1963

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 Allen C. McSpadden

Licensed Embalmer No. 4543

P. O. Address Van Buren, 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.