

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024404

6670

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6670

FILED JUL 12 1962

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
a. COUNTY		ST. LOUIS, MISSOURI				MISSOURI		WASHINGTON		POTOSI, MISSOURI		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
BARNES HOSPITAL						813 N. MISSOURI													
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH		Month		Day		Year	
ANNIE W. BENSON												JULY		6		1962			
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR Months		IF UNDER 24 HR Days		Hours		Min.			
FEMALE		WHITE				2/28/1885		77											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY							
HOUSEWIFE				HOME				PALMER, MISSOURI				U. S. A.							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
WILLIAM HAGARD				EVELYN WILKERSON				BILL GRAVES				POTOSI, MISSOURI							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address							
NO				NONE				BILL GRAVES				POTOSI, MISSOURI							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>GANGRENE OF LARGE AND SMALL BOWEL</u>												36 HOURS							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																			
DUE TO (b) <u>SUPERIOR MESENTERIC ARTERY THROMBOSIS</u>												36 HOURS							
DUE TO (c) <u>ATHEROSCLEROSIS</u>												7501 YEARS							
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 checked="" 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		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>MAY 25, 1957</u> to <u>JULY 6, 1962</u> and last saw her/him alive on <u>JULY 6, 1962</u> Death occurred at <u>11:25 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i>								22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 7/6/62							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				23e. STATE							
BURIAL		7/9/62		NEW MASONIC CEMETERY				POTOSI, MISSOURI											
24. FUNERAL DIRECTOR				ADDRESS				25. DATE RCD. BY LOCAL REG.				26. REGISTRAR'S SIGNATURE							
SPARKS				POTOSI, MISSOURI				JUL 6 1962				<i>Earl Smith, M.D.</i>							

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 Ronald Sparks

Licensed Embalmer No. 4819

P. O. Address Kotosi, 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.