

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027561

STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 124

FILED JUL 26 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Jasper | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR Carthage | | Length of stay in lb 1 Week | c. CITY OR TOWN Carthage Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune Brooks Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Fair Acres Rest Home Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Katherine Sanders | | | 4. DATE OF DEATH Month July Day 15 Year 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/12/87 |
| 9. AGE (last birthday) 75 | | 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) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Carthage Missouri |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Phelps Ferguson | |
| 13b. MOTHER'S MAIDEN NAME Martha Jane Cooker | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None None | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Mrs. Lois Nebelsick, Carthage Mo. 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) Bronchopneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs - |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease with acute congestive failure - | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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 Carthage, Mo - |
| 20g. COUNTY _____ | | 20h. STATE _____ | |
| 21. I attended the deceased from July 14, 1962 , to July 15, 1962 and last saw her alive on July 15, 1962 . Death occurred at 4:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Charles J. Isbell, MD</i> (Degree or title) | | 22b. ADDRESS Carthage, Mo - | 22c. DATE SIGNED 7/15/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 17, 1962 | 23c. NAME OF CEMETERY OR CREMATORY I.O.O.F | 23d. LOCATION (City, town, or county) (State) Neosho Missouri |
| 24. FUNERAL DIRECTOR Thompson Funeral Home, Neosho Mo. ADDRESS _____ | | 25. DATE RECD. BY LOCAL REG. 7-16-62 | 26. REGISTRAR'S SIGNATURE <i>Ely Chutkan</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 Jimmy C. Jobe

Licensed Embalmer No. 5140

P. O. Address Trueto, 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.