

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034137  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 25 Primary Registration District No. 3015 Registrar's No. 92

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 24 1962

VS 300  
Rev. 4/59

10251  
20320

3  
4 1  
5 0  
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8 2  
94200

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11  
121-2  
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>DeKalb</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Length of stay in 1b <b>47 Days</b>	c. CITY OR TOWN <b>Maysville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Community Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Maysville</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BERNICE</b> Middle <b>HELEN</b> Last <b>GILBERT</b>			4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 13 1885</b>
9. AGE (last birthday) <b>77</b>		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) <b>Retired Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Maysville Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>William Gilbert</b>	
13b. MOTHER'S MAIDEN NAME <b>Matilda Holmes</b>		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) <b>No</b>		16. SOCIAL SECURITY NO. <b>Informant</b>	
17. ADDRESS <b>Gilbert H. Reynolds 5001 State Line Road, Kansas City (12) Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Acute massive myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
DUE TO (b) <b>Arteriosclerotic Heart disease</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) <b>Chronic hypertension; Cerebral hemorrhage 7-31-62</b>		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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
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 <b>July 21, 1962</b> to <b>Sept 15, 1962</b> and last saw her alive on <b>Sept 14, 1962</b> Death occurred at <b>8:10 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. O. Bloom</i>		(Degree or title) <b>R.O.</b>	
22b. ADDRESS <b>Cameron, Missouri</b>		22c. DATE SIGNED <b>9-15-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9/15-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Maysville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Maysville Missouri</b>	
24. FUNERAL DIRECTOR <b>Pilcher Funeral Home Maysville Mo</b>		25. DATE RECD. BY LOCAL REG. <b>9-17-62</b>	
26. REGISTRAR'S SIGNATURE <i>Francis D. Rayford</i>			

USE BLACK INK OR TYPEWRITER RIBBON

Form 1 Obtained 9-17-62

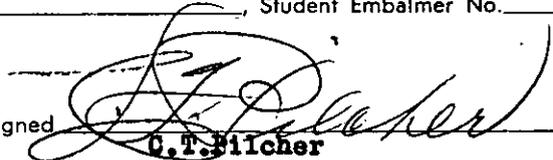
STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
MAYSVILLE, MISSOURI  
OFFICE OF THE HEALTH COMMISSIONER  
MAYSVILLE, MISSOURI  
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MAYSVILLE, MISSOURI

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   
O.T. Sticher

Licensed Embalmer No. 3960

P. O. Address Maysville 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.

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