

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035393

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS SUB

AMENDED

Registration District No. 127
FILED OCT 5 1962

Primary Registration District No. 3040

Registrar's No. ~~199~~

STATE FILE NUMBER

VS 300
Rev. 4/59

10593

20595

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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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY LIVINGSTON		a. STATE MO. b. COUNTY LIVINGSTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE		c. CITY OR TOWN CHILLICOTHE	
Length of stay in 1b 50 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL		d. STREET ADDRESS (If outside, give location) 209 BRIDGE ST.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED		4. DATE OF DEATH	
First Middle Last GARNET MC/KINLEY GERMAN		Month Day Year OCTOBER 2 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 3/2/1896
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) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (City and state or country) GALT, MISSOURI
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME ROME GERMAN	
13b. MOTHER'S MAIDEN NAME BERTHA OREN		14. NAME OF HUSBAND OR WIFE ADELINE E. HICKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. G.M. GERMAN		Address 209 Bridge St. Chillicothe, Mo.	
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) Cerebral Arterial Thrombosis			
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) Chr. myosinitis		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 s.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 <u>3-29-61</u> to <u>10-2-62</u> and last saw him alive on <u>10-1-62</u> Death occurred at <u>4:20</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W. Powell, M.D.</i>		22b. ADDRESS <i>Chillicothe MO</i>	22c. DATE SIGNED <i>10-2-62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10/4/62	23c. NAME OF CEMETERY OR CREMATORY RESTHAVEN CEMETERY	23d. LOCATION (City, town, or county) (State) CHILLICOTHE, MISSOURI
24. FUNERAL DIRECTOR NORMAN FUNERAL HOME: Chillicothe, Mo.		25. DATE RECD. BY LOCAL REG. <i>Oct 3, 1962</i>	26. REGISTRAR'S SIGNATURE <i>Amalee Taylor</i>

OCT 9 1962

MISSOURI

Date Taken to Dr. Dowell 10/2/62

Date Rec'd. from Dr. Dowell _____ 1962

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

John P. Rodgers

Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, MISSOURI

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.