

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-035839

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 3019 Registrar's No. 401

FILED SEP 25 1962

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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 St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Washington	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		Length of stay in 1b 10 days	c. CITY OR TOWN Potosi Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R#2-Hy. 8 West Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Laura Isabelle Halbert			4. DATE OF DEATH Month Day Year Sept 2 1962
5. SEX Female	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/5/85
9. AGE (last birthday) 77		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 Own Home	11. BIRTHPLACE (City and state or country) Sulphur Spgs., Tenn.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Thomas Floyd	
13b. MOTHER'S MAIDEN NAME Clemmie Perkins		14. NAME OF HUSBAND OR WIFE Walter Halbert (dcd)	
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. none	17. INFORMANT Address Mrs. Essie Campbell, R#2, Potosi Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertension DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 days
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 8-23-62 to 9-2-62 and last saw her ^{him} alive on 9-2-62 Death occurred at 9:45 a. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>[Signature]</i>	
22b. ADDRESS Bonne Terre, Mo.		22c. DATE SIGNED 9-10-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal &	23b. DATE 9/10/62	23c. NAME OF CEMETERY OR CREMATORY Caledonia Methodist	23d. LOCATION (City, town, or county) (State) Washington Co., Missouri
24. BURIAL DIRECTOR ADDRESS Gum & Son Potosi, Mo		25. DATE RECD. BY LOCAL REG. Sept. 10, 1962	26. REGISTRAR'S SIGNATURE <i>[Signature]</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

William A. Gurn

Licensed Embalmer No.

5155

P. O. Address

Peters 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.