

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037798
STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1035

FILED OCT 16 1962

WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY OREGON	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in lb 6 DAYS	c. CITY OR TOWN ALTON Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) BOX 1126 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILEY Middle NMI Last FREY			4. DATE OF DEATH Month Sept Day 23 Year 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 10-16-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) COUCH, MO.
13a. FATHER'S NAME HENRY FREY		13b. MOTHER'S MAIDEN NAME PARALEE ROBERTSON	14. NAME OF HUSBAND OR WIFE LAURA FREY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWT		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA, HOSPITAL RECORDS, POPLAR BLUFF, 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) THROMBOSIS OF UNSPECIFIED CEREBRAL ARTERY DUE TO (b) ARTERIOSCLEROSIS DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 Days Unknown
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 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 _____ 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 VA COUNTY _____ STATE _____
21. VA attended the deceased from Sept 17, 1962 to Sept 23, 1962 and last seen her alive on 10:17AM on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at _____			
22a. SIGNATURE <i>Robert S. Cohen</i> ROBERT S. COHEN M.D. Chief, Med. Svc.		22b. ADDRESS VA. HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 9-28-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-25-1962	23c. NAME OF CEMETERY OR CREMATORY Cotton Creek Cemetery	23d. LOCATION (City, town, or county) (State) Jobe, Missouri
24. FUNERAL DIRECTOR ADDRESS Carter Funeral Home, Thayer, Mo.		25. DATE RECD. BY LOCAL REG. 10/11/1962	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</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 *Leland Carter*

Licensed Embalmer No. 4516

P. O. Address *Hayes, 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.