

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-039825

STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 2056 Registrar's No. 254

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 30 1962

<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>Randolph</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u> Length of stay in lb <u>all life</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1604 Schuneman</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>Randolph</u></p> <p>c. CITY OR TOWN <u>Moberly</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>1604 Schuneman</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p><b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>ROBERT PREWITT</u></p>		<p><b>4. DATE OF DEATH</b> Month Day Year <u>October - 9 - 1962</u></p>	
<p><b>5. SEX</b> <u>Male</u></p>	<p><b>6. COLOR OR RACE</b> <u>White</u></p>	<p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>2-21-1903</u></p>
<p><b>9. AGE</b> (last birthday) <u>59</u></p>		<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Labor</u></p>	<p><b>11. BIRTHPLACE</b> (City and state or country) <u>Moberly Mo.</u></p>
<p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u></p>		<p><b>13. FATHER'S NAME</b> <u>Dabney Prewitt</u></p>	
<p><b>14. MOTHER'S MAIDEN NAME</b> <u>Dora A. Huston</u></p>		<p><b>15. NAME OF HUSBAND OR WIFE</b> <u>Lillian Mae Prewitt</u></p>	
<p><b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u></p>		<p><b>17. SOCIAL SECURITY NO.</b> <u>None</u></p>	
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>IMMEDIATE CAUSE (a) <u>leucocyanic infarction massive</u></p>		<p><u>10 min</u></p>	
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>		<p>DUE TO (b) <u>cardiac asthma</u></p>	
		<p>DUE TO (c) <u>Bronchial asthma</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>		<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>	<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p><b>20c. TIME OF INJURY</b> Hour s.m. p.m. Month, Day, Year</p>			
<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
		<p><b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE</p>	
<p><b>21. I attended the deceased from</b> <u>Feb-1962</u> to <u>Oct 9, 1962</u> and last saw him alive on <u>Oct 9, 1962</u></p> <p>Death occurred at <u>8:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p><b>22a. SIGNATURE</b> (Degree or title) <u>Leij A. Jolly D.O.</u></p>		<p><b>22b. ADDRESS</b> <u>203 1/2 N. Clark, Moberly Mo.</u></p>	
		<p><b>22c. DATE SIGNED</b> <u>10-9-62</u></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u></p>	<p><b>23b. DATE</b> <u>Oct-11-1962</u></p>	<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Antioch Cemetery</u></p>	<p><b>23d. LOCATION</b> (City, town, or county) (State) <u>East of Moberly Mo.</u></p>
<p><b>24. FUNERAL DIRECTOR</b> <u>Cater Funeral Home Moberly Mo.</u> ADDRESS</p>		<p><b>25. DATE RECD. BY LOCAL REG.</b> <u>Oct 11-62</u></p>	<p><b>26. REGISTRAR'S SIGNATURE</b> <u>Leah R. Coe</u></p>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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**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 R. M. Carter

Licensed Embalmer No: 14117  
P. O. Address Moherby 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.