

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041300

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 109

FILED OCT 19 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1035
2 0161
3 2
4 0
5 1
6
7 0
8 2
9 94500
10
11
12 86-2
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Stoddard County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dexter</u>		Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>Jackson</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Green Meadow Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>345 West Adams St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Lee Call</u>			4. DATE OF DEATH Month Day Year <u>Sept. 26, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/1875</u>
9. AGE (last birthday) <u>86</u>		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Bollinger County</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Joe Call</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Crump Call</u>		14. NAME OF HUSBAND OR WIFE <u>Charolette Thorn Call</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address <u>Charolette Call, Jackson, Missouri</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
DUE TO (b) <u>Congestive heart failure</u>			<u>1 week.</u>
DUE TO (c) <u>arteriosclerosis</u>			<u>unknown</u>
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>9/19/62</u> to <u>9/26/62</u> and last saw him alive on <u>Sept. 26, 1962</u> Death occurred at <u>2:35 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Glenn C. Northrup D.O.</u>		22b. ADDRESS <u>Dexter, Mo.</u>	22c. DATE SIGNED <u>9/27/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>9/28/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>	23d. LOCATION (City, town, or county) (State) <u>Jackson, Missouri</u>
24. FUNERAL DIRECTOR <u>Cracraft-Miller,</u>	ADDRESS <u>Jackson, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-13-62</u>	26. REGISTRAR'S SIGNATURE <u>Velma V. Jensen</u>

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 *[Handwritten Signature]*

Licensed Embalmer No. 4327
P. O. Address *[Handwritten Address]*

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.