

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000094

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 10 Primary Registration District No. 5037 Registrar's No. 51

FILED FEB 15 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10047

20040

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cudrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cudrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b <u>10 yrs.</u>	c. CITY OR TOWN <u>Mexico</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Coldwell Nurs. Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>W. S. U.</u>
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Katherine</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5 Dec 1869</u>
9. AGE (last birthday) <u>93</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Middletown, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. C.</u>		13. FATHER'S NAME <u>James D. Cowherd</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Layson</u>		15. NAME OF HUSBAND OR WIFE <u>Henry Martin</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of)		17. SOCIAL SECURITY NO. _____	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>		years <u>years</u>	
DUE TO (c) _____		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 COUNTY STATE	
21. I attended the deceased from <u>9-27-62</u> to <u>2-5-63</u> and last saw <u>him</u> alive on <u>1-31-63</u> Death occurred at <u>11:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William W. Bradley MD</u>		22b. ADDRESS <u>Box 178, Farley, Mo.</u>	
22c. DATE SIGNED <u>2-11-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>7 Feb 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Unxvasse</u>	
23d. LOCATION (City, town, or county) (State) <u>Cudrain Mo.</u>		24. FUNERAL DIRECTOR <u>Funeral Home Fulton, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>Feb 11-1963</u>		26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>	

USE BLACK INK OR

TYPEWRITER RIBBON

William W. Bradley MD

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 Gene C. Yauger

Licensed Embalmer No. 5092

P. O. Address Fulton, MD

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.