

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000220

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 37 Primary Registration District No. 5219 Registrar's No. 4

FILED JAN 30 1963

VS 300  
Rev. 4/59

10100  
3100

3  
4 1  
5 1  
6  
7 1  
8 2

94200

10

11

1290-0  
132-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Centralia</b>		Length of stay in 1b <b>since 1940</b>	c. CITY OR TOWN <b>Centralia</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 4, Centralia, Mo</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 4</b> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Hazel</b> Middle <b>Brown</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>25</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (last birthday) <b>63</b> IF UNDER 1 YEAR: Months <b>10</b> Days <b>10</b> IF UNDER 24 HR: Hours <b>10</b> Min. <b>10</b>
11. BIRTHPLACE (City and state or country) <b>Bloomington, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Jeptha R. Cornelison</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Allison</b>	14. NAME OF HUSBAND OR WIFE <b>Earl D. Brown</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Earl D. Brown, Centralia, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio Sclerotin heart disease and Hypertensive Cardio Vascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Osteo Arthritis</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>6/12/55</b> to <b>1/25/63</b> and last saw her/him alive on <b>1/22/63</b> Death occurred at <b>5 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert L. Ward M.D.</i> (Degree or title)		22b. ADDRESS <b>120 N. Rollins, Centralia</b>	22c. DATE SIGNED <b>1-26-63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 28, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Centralia, Mo.</b>	23d. LOCATION (City, town, or county) (State) <b>Centralia, Mo.</b>
24. FUNERAL DIRECTOR <i>Bessie M. Meador Centralia, Mo.</i>		25. DATE RECD. BY LOCAL REG. <b>Jan. 28, 1963</b>	26. REGISTRAR'S SIGNATURE <i>Maud M. Bride</i>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

JAN 14 1964

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

*Bill J. Meador*

Licensed Embalmer No. 4876

P. O. Address Centralia, Missouri

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.

Permit issued Jan 28 1964