

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000567

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 1

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0147  
2 3008

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1293-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**FILED JAN 15 1963**

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>34 yrs. 7 mo.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle _____ Last <u>Thomas</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>1963</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1886?</u>
9. AGE (last birthday) <u>76 ?</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>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>unk</u>	
14. MOTHER'S MAIDEN NAME <u>unk</u>		15. NAME OF HUSBAND OR WIFE <u>none</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>		17. INFORMANT Address <u>State Hospital No. 1, Fulton, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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. <input checked="" type="checkbox"/> attended the deceased from <u>State Hospital No. 1</u> <u>5-8-1928</u> to <u>1-5-1963</u>		Death occurred at <u>4:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Fulton, Missouri</u>	
22c. DATE SIGNED <u>1/7/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-8-63</u>		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City, town, or county) (State) <u>Columbia Mo.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Columbia Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 8-1963</u>	
		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_ Signed \_\_\_\_\_  
Signature of Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

P. O. 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.