

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000694

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. \_\_\_\_\_ Registrar's No. 21

**FILED FEB 13 1963**

1. PLACE OF DEATH a. COUNTY <b>CASS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>CASS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>PECULIAR Twp</b>		Length of stay in 1b <b>3 yrs.</b>	c. CITY OR TOWN <b>HARRISONVILLE</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>Pleasant View Rest Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Pleasant View Rest Home</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WILLIAM HENRY TRIBBY</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>5</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (last birthday) <b>87</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11a. FATHER'S NAME <b>George W. TRIBBY</b>		11b. MOTHER'S MAIDEN NAME <b>MARY FRANCES Ashley</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs Robert ANDERSON - Archie, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiac insufficiency</b> DUE TO (c) <b>arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH. <b>2da</b>
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 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 <b>1955</b> to <b>Feb 5</b> and last saw <sup>her</sup> him alive on <b>Feb 5, 1963</b> Death occurred at <b>2:10 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R. E. Knoch MD</b>		22b. ADDRESS	22c. DATE SIGNED <b>2-7-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2/7/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FREEMAN Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>FREEMAN, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Atkinson-Dickey Harrisonville, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>2-7-63</b>	26. REGISTRAR'S SIGNATURE <b>Ray J. Sebec</b>

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

VS 300  
Rev. 4/59  
1 1190  
2 0190  
3  
4 0  
5 2  
6  
7 1  
8 0  
9 4221  
10  
11  
12 86-2  
13 2-0

**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 Robert W. Catterino

Licensed Embalmer No. 7902

P. O. Address Harrison, N.J.

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.