

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-002408

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 980 Primary Registration District No. 9039 Registrar's No. 279 STATE FILE NUMBER

**FILED JAN 14 1963**

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Length of stay in 1b <u>42 yrs</u>	c. CITY OR TOWN <u>Brookfield</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>837 Brookfield Avenue</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>837 Brookfield Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HARRY WESTERN</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>1963</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>1-21-1889</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rural mail carrier, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post office</u>	11. BIRTHPLACE (City and state or country) <u>Linneus, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles B. Western</u>	
13b. MOTHER'S MAIDEN NAME <u>Mancy Jane Kirby</u>		14. NAME OF HUSBAND OR WIFE <u>Pauline Cotter Western</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT Address <u>Mrs. Pauline Western, Brookfield, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hr</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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>	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 <u>  </u> STATE <u>  </u>
21. I attended the deceased from <u>2-28-49</u> to <u>1-9-63</u> and last saw <u>her</u> alive on <u>12-20-62</u> Death occurred <u>10</u> a <u>  </u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John R. Duff</u> (Degree or title) <u>  </u>		22b. ADDRESS <u>Brookfield, Mo.</u>	22c. DATE SIGNED <u>1-9-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 11, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Brookfield, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-10-63</u>	26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

VS 300  
Rev. 4/59  
1 0585  
2 0585a  
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1290-0  
132-0

USE BLACK INK OR TYPEWRITER RIBBON

JAN 16 1963

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

*Harold B. Wright*

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

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.