

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-002920

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 282 Primary Registration District No. \_\_\_\_\_ Registrar's No. 18

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED FEB 15 1963</b>	
1. PLACE OF DEATH a. COUNTY <u>Polk</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Polk, Mo</u> Length of stay in 1b <u>87 Years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Polk</u> c. CITY OR TOWN <u>Polk</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>RT 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First <u>Etra</u> Middle <u>Gay</u> Last <u>Renfro</u>	
4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Feb 10 1876</u>
9. AGE (last birthday) <u>87</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>None</u>
11. BIRTHPLACE (City and state or country) <u>Polk County</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Elbert Payne</u>	13b. MOTHER'S MAIDEN NAME <u>Louise Armstrong</u>
13c. NAME OF HUSBAND OR WIFE <u>James Renfro Deceased</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. _____
17. INFORMANT <u>Lawrence Miller</u>	Address <u>Polk, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Inanition &amp; Debilitation</u> DUE TO (c) <u>Arterio-sclerosis</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 _____ 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>1956</u> to <u>Feb 10, 1963</u> and last saw her alive on: <u>Feb 5, 1963</u> Death occurred at: <u>8:00 P.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>M. J. Cumber</u> (Degree or title) _____	22b. ADDRESS <u>Bolivar Mo.</u>
22c. DATE SIGNED <u>2/12/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/13/63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Payne Cemetery</u>	23d. LOCATION (City, town, or county) <u>Polk</u> (State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>Paul D. Butler</u> ADDRESS <u>Bolivar, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 12, 1963</u>
26. REGISTRAR'S SIGNATURE <u>Ralph Gordon per J. G.</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

10840

20840

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94500

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USE BLACK INK OR TYPEWRITER RIBBON

Permit issued Feb 19, 1963 J.B.

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 Paul D Butler

Licensed Embalmer No. 4471

P. O. Address Bolivar, 1770

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.