

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-002998

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 5

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 17 1963

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u>		c. CITY OR TOWN <u>Moberly</u>	
Length of stay in 1b <u>4 1/2 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodlind Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>546 Barrow</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE MARIE ROOP</u>			4. DATE OF DEATH Month Day Year <u>January - 7 - 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>3-27-1900</u>
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	9. AGE (last birthday) <u>62</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
13a. FATHER'S NAME <u>Chief Dale</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs. Elizabeth Raft</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		14. SOCIAL SECURITY NO.	14. NAME OF HUSBAND OR WIFE <u>None</u>
17. INFORMANT <u>Mrs. Mildred Hagen</u>		Address <u>Kansas City Kansas</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus with coma and acidosis.</u> DUE TO (b) <u>Diabetes mellitus.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 years.</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.	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 <u>Oct. 1958</u> to <u>Jan. 7, 1963</u> and last saw her <u>alive</u> on <u>Jan. 7, 1963</u> Death occurred at <u>5:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Will Stern M.D.</u>		22b. ADDRESS <u>Moberly Mo.</u>	22c. DATE SIGNED <u>1-9-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Jan - 10 - 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Moberly Missouri</u>
24. FUNERAL DIRECTOR <u>Cater Funeral Home</u>	ADDRESS <u>Moberly Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-10-63</u>	26. REGISTRAR'S SIGNATURE <u>Jack S. Lowe</u>

VS 300 Rev. 4/59

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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

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 _____

H. M. Cater

Licensed Embalmer No. H117

P. O. Address Proberly 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.