

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005877

STATE FILE NUMBER

Registration District No. 101 Primary Registration District No. _____ Registrar's No. 10

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1340

2340

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9331X

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED FEB 18 1963

1. PLACE OF DEATH
a. COUNTY Douglas

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Douglas

b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN _____ Length of stay in 1b _____
c. CITY OR TOWN Ava Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Goodhope Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) Route 3, Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Mary (Molly) Buchanan Camp

4. DATE OF DEATH Month: Day: Year: Feb. 2, 1963

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 11-26-77 9. AGE (last birthday) 85 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (City and state or country) Hartville, Missouri 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Unknown 13b. MOTHER'S MAIDEN NAME Reece 14. NAME OF HUSBAND OR WIFE Emma Fullbright Homer Camp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Address Homer Camp, Ava, Missouri, Route

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 10da.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) essential Hypertension 10y.
DUE TO (c) _____

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 1-24-63 to 2-2-63 and last saw her alive on Feb 2-63. Death occurred at 4:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) Dr. P. J. Harlan D.O. 22b. ADDRESS Ava Mo. 22c. DATE SIGNED 2-4-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 2-3-63 23c. NAME OF CEMETERY OR CREMATORY Denney 23d. LOCATION (City, town, or county) (State) Route, Ava, Missouri

24. FUNERAL DIRECTOR ADDRESS Clinkingbeard Funeral Home, Ava, Mo. 25. DATE RECD. BY LOCAL REG. 2-11-63 26. REGISTRAR'S SIGNATURE Ustala Bushman

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

Charles R. Fish

Licensed Embalmer No. 4662

P. O. Address Over 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.