

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

(DEPARTMENT OF PUBLIC HEALTH AND WELFARE)

-63-006068

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 322

WS:300
Rev. 4/59

6397
3397

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1292-0
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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FIDELITY

FILED MAR 6 1963	
1. PLACE OF DEATH a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in lb <u>hrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. City Hospital</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>Missouri</u> b. COUNTY <u>Green</u> c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>725 E. High</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
13. NAME OF DECEASED First Middle Last <u>Mina Rea</u>	
4. DATE OF DEATH Month Day Year <u>February 27, 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>3/9/1874</u>
9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days 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
11. BIRTHPLACE (City and state or country) <u>Cedarbluff, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jacob Stewart</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Day</u>
14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of) <u>none</u>	17. INFORMANT Address <u>Loone Brockus Springfield, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>1961</u> to <u>Feb. 27, 1963</u> and last saw her alive on <u>D.O.A.</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Leman D. Brown M.D.</u>	22b. ADDRESS <u>311 1/2 College</u>
22c. DATE SIGNED <u>3/2/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/2/1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood</u>	23d. LOCATION (City, town, or county) <u>Springfield, Missouri</u>
24. FUNERAL DIRECTOR <u>Chapel of the Ozarks, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Mar 5, 1963</u>
26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

MAR 19 1963

Print Me 4, 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 Hal Roger Duff Student Embalmer No. 677

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvard B. Lohr

Licensed Embalmer No. 5159

P. O. Address Springfield

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.