

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007571

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 65

FILED MAR 7 1963

VS 300
Rev. 4/59

1 0595

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12 86-2

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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

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY LIVINGSTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY LIVINGSTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE		Length of stay in 1b 54 YRS.	c. CITY OR TOWN CHILLICOTHE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION SUSAN'S NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 439 CHERRY ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MOLLIE MYRTLE SMITH			4. DATE OF DEATH Month Day Year MARCH 1 1963
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-1-78
9. AGE (last birthday) 84		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) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) LIVINGSTON CO., MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME BILL WILBURN	
13b. MOTHER'S MAIDEN NAME TOBITHA WILBURN		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, unknown) (If yes, give war or dates of) NO		17. INFORMANT MRS. WM. COTHRAN 4121 GLENCAREN LANE INDIANAPOLIS, IND.	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Pulmonary Embolism DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 72 hr. 7 days
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 Chillicothe, Mo.	COUNTY _____ STATE _____
21. I attended the deceased from <u>5-10-59</u> to <u>3-2-63</u> and last saw her ^{him} alive on <u>3/2/63</u> Death occurred at <u>10:30</u> P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>P. W. Matheny</i> (Degree or title) <u>190.</u>		22b. ADDRESS <u>Chillicothe, Mo.</u>	22c. DATE SIGNED <u>3/2/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-3-63	23c. NAME OF CEMETERY OR CREMATORY EDGEWOOD CEMETERY	23d. LOCATION (City, town, or county) CHILLICOTHE, MISSOURI
24. FUNERAL DIRECTOR NORMAN FUNERAL HOME: Chillicothe, Mo.		25. DATE RECD. BY LOCAL REG. MAR 2, 1963	26. REGISTRAR'S SIGNATURE <i>Annalee Taylor</i>

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

John P. Rogers

Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, MISSOURI

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.