

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007606

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 37

STATE FILE NUMBER

FILED MAR 12 1963

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u>		c. CITY OR TOWN <u>Macon</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Samaritan Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>811 Jackson</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>CATHYRN</u> Last <u>THOMAS</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</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>12/19/1875</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>At Home</u>	11. BIRTHPLACE (City and state or country). <u>Eckard Mines, Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>William Scheller</u>	
13b. MOTHER'S MAIDEN NAME <u>Isabelle Close</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Marion Showen Macon, Mo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>NO</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. Marion Showen</u>		Address <u>Macon, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> DUE TO (b) <u>Stroke</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 Hours</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>Macon, Mo.</u>	
20g. COUNTY _____ STATE _____		21. I attended the deceased from <u>Jan 15 1963</u> to <u>Feb 14 1963</u> and last saw her alive on <u>Feb 14 1963</u> Death occurred at <u>6:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>Macon, Mo.</u>	
22c. DATE SIGNED <u>2/16/63</u>		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Fe. 16, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Richardsdale</u>		23d. LOCATION (City, town, or county) <u>Bevier Mo.</u>	
24. FUNERAL DIRECTOR <u>Roger B. Bunn</u>		25. DATE RECD: BY LOCAL REG. <u>3-9-63</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		26. (State)	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

DATE AMENDED
 VS 300 Rev. 4/59
 1 0611
 2 0611
 3
 4 1
 5 2
 6
 7 1
 8 0
 9 9431X
 10
 11
 12 1-2
 13 1-0
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

MAY 9 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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

R. Lester B. [unclear]

Licensed Embalmer No. 4472

P. O. Address Marion, 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.