

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-015350

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 62

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 6001

2 6001

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 14 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Clay</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> Length of stay in 1b <u>1</u> years</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>102 Southview Drive</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u></p> <p>c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>102 Southview Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Ralph</u> Middle <u>James</u> Last <u>Masters</u></p>	<p>4. DATE OF DEATH</p> <p>Month <u>April</u> Day <u>25</u> Year <u>1963</u></p>
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>White</u></p>
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>11/10/1891</u></p>
<p>9. AGE (last birthday) <u>71</u></p>	<p>10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>Maryville, Missouri</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>Edwin Masters</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Georgia</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>Violet Masters</u></p>	<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>
<p>16. SOCIAL SECURITY NO. <u>[REDACTED]</u></p>	<p>17. INFORMANT <u>Mrs Violet Masters, Excelsior Springs, Mo</u> Address <u>[REDACTED]</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u></p> <p style="text-align: center;">DUE TO (b) <u>Arteriosclerosis</u></p> <p style="text-align: center;">DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>Pure Degenerative Arteriosclerosis</u></p> <p>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</p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u></p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>	<p>20e. PLACE OF INJURY. (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from <u>1-29-63</u> to <u>April-25</u> and last saw ^{her} him alive on <u>4-25-63</u></p> <p>Death occurred at <u>8:00</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Joseph B. Schaubert MD</u></p>	<p>22b. ADDRESS <u>Excelsior Springs, Mo</u></p>
<p>22c. DATE SIGNED <u>4-27-63</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>4/27/1963</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u></p>	<p>23d. LOCATION. (City, town, or county) <u>Maryville, Missouri</u> (State) _____</p>
<p>24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> ADDRESS <u>Excelsior Springs, Missouri</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>4-26-63</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u></p>	

USE BLACK INK OR TYPEWRITER RIBBON

Removal permit issued 4-26-63 6:57

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 Lowell Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.