

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015421

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 183 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300
REV 4/59

9269
02692

3
4 1
5 1
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7 0
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9204.0
10
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12 1-2
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

FILED MAY 3 1963	
1. PLACE OF DEATH a. COUNTY <u>Cole</u>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u> Length of stay in 1b <u>5 days</u>	
c. CITY OR TOWN <u>Jefferson City</u> 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>Charles E. Still Osteopathic Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>1009 Madison</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>SYLVIA</u> Middle <u>LEE</u> Last <u>PONDER</u>	
4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-08</u>
9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
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> </u>
11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Luther McKee</u>	
13b. MOTHER'S MAIDEN NAME <u>Nettie Sapp</u>	
14. NAME OF HUSBAND OR WIFE <u>Clay Ponder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Clay Ponder 1009 Madison - Jefferson</u> City, Mo. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u> 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 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.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u> </u> to <u>4-26-63</u> and last saw her alive on <u>4-26-63</u> Death occurred at <u>1:05 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>L. E. Gifford</u> (Degree title) <u> </u>	
22b. ADDRESS <u> </u>	
22c. DATE SIGNED <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>4-25-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery NEAR MARION, Missouri</u>	
23d. LOCATION (City, town, or county) (State) <u> </u>	
24. FUNERAL DIRECTOR <u>Jenker Funeral Home Inc. J.G.Mo.</u> ADDRESS <u> </u>	
25. DATE RECD. BY LOCAL REG. <u>30 April 1963</u>	
26. REGISTRAR'S SIGNATURE <u>R.P. Darrin - Registrar</u>	

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

Omer Edward Jones

Licensed Embalmer No.

2411

P. O. Address

Belle 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.

RECEIVED