

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015482
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 98 Primary Registration District No. 4165 Registrar's No. _____

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gallatin</u>		Length of stay in 1b <u>4 Months</u>	c. CITY OR TOWN <u>Rural Marion Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mead Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Civil Bend Community</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>--</u> Last <u>Duffey</u>			4. DATE OF DEATH Month <u>May</u> Day <u>3</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>4-18-1869</u>
9. AGE (last birthday) <u>94</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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Daviess Co., Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Anderson H. Garrison</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Polk</u>		14. NAME OF HUSBAND OR WIFE <u>Chas. Duffey (Dec'd)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of _____) <u>No</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>Mrs. Wiley Burns, Gallatin, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterial Sclerosis, Hypertension</u>			<u>5 yr</u>
DUE TO (c) <u>nephritis & pyelitis</u>			<u>4 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>fracture of rt hip 1 1/2 yrs ago & left leg 3 yrs ago</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 <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 checked="" 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>June 1899</u> to <u>May 3</u> and last saw him alive on <u>May 3</u> . Death occurred at <u>11:45 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm. L. D.</u> (Degree or title)		22b. ADDRESS <u>Gallatin Mo</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-5-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Civil Bend Christian Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Daviess Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Hope Funeral Home, Gallatin, Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>5-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Virgie M. Engelhart</u> <u>Wm. L. D. Dep.</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

L. Dickerson

Licensed Embalmer No.

3307

P. O. Address

Reliance No.

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.