

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-016513

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 162 Primary Registration District No. 5546 Registrar's No. 42

VS 300
Rev. 4/59

1 0500

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12 86-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

FILED MAY 1 1963	
1. PLACE OF DEATH	
a. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rock Township</u> Length of stay in 1b <u>1 Yrs</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 Oaks Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. STATE <u>Mo</u> b. COUNTY <u>Madison</u>	
c. CITY OR TOWN <u>Marquand</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>Marquand G. D.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Nevada Estes</u>	
4. DATE OF DEATH Month Day Year <u>April 20 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>Dec 18 1871</u>
9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>
11. BIRTHPLACE (City and state or country) <u>Millersville Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>Joseph Zimbaugh</u>	13b. MOTHER'S MAIDEN NAME <u>Falitha Miller</u>
14. NAME OF HUSBAND OR WIFE <u>(dec) E.V. Estes</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>Clyde Estes St Louis Mo</u>
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>Cerebral Arteriosclerosis</u>	
DUE TO (b) _____	
DUE TO (c) _____	
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 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 COUNTY STATE	
21. I attended the deceased from <u>1/20/62</u> to <u>4/20/63</u> and last saw her alive on <u>4/20/63</u>	
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Charles Burnside, M.D.</u>	22b. ADDRESS <u>206 W. Argonne Kirkwood</u>
22c. DATE SIGNED <u>4/20/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 20 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Madison County Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Homan Funeral Home Marquand Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Apr 23 1963</u>
26. REGISTRARS SIGNATURE <u>Robert E. Bauer</u>	

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 Elmer A. Hightag

Licensed Embalmer No. 3571

P. O. Address Imperial 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.