

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-018892
STATE FILE NUMBER

Registration District No. 375 Primary Registration District No. 4279 Registrar's No. 9

DO NOT WRITE ON THIS STUB

VS 300	DATE AMENDED	AMENDED
Rev. 4/59		
1140		
2 1140		
3		
4 1		
5 1		
6		
7 0		
8 0		
94201		
10		
11		
12 70-0		
13 1-0		
ITEM NO.	SHOULD READ	SHOULD BE AS FOLLOWS

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED APR 25 1963	
1. PLACE OF DEATH a. COUNTY <u>Wright</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gasconade Township</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wright</u> c. CITY OR TOWN <u>Mansfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Rt 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>Curtis</u> Last	4. DATE OF DEATH Month <u>April</u> Day <u>11</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>11-8-1901</u> 9. AGE (last birthday) <u>61</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	11. BIRTHPLACE (City and state or country) <u>Texas County, Mo.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Tom Mayfield</u> 13b. MOTHER'S MAIDEN NAME <u>Belle Trusty</u>	14. NAME OF HUSBAND OR WIFE <u>H. M. Curtis</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>[redacted]</u> 17. INFORMANT <u>H. M. Curtis, Mansfield, Mo.</u> Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis, Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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>Aug 1960</u> to <u>April 11, 63</u> and last saw her alive on <u>4-4-63</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>[Signature]</u>	22b. ADDRESS <u>[Address]</u>
22c. DATE SIGNED <u>4-22-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 14-63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Boone Creek</u>	23d. LOCATION (City, town, or county) (State) <u>Texas County Mo.</u>
24. FUNERAL DIRECTOR <u>Bergman-Miller</u> ADDRESS <u>Mansfield, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-24-1963</u> 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MAY 7 1963

Removal Permit Obtained

11
45
40
1
0
0
0
0

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield 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.