

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-019043
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 352

DO NOT WRITE ON THIS STUB AMENDED

VS 300 Rev. 4/59	DATE AMENDED
1 <u>0109</u>	
2 <u>1070-</u>	
3	
4 <u>1</u>	
5 <u>1</u>	
6	
7 <u>0</u>	
8 <u>1</u>	
9 <u>2044</u>	
10	
11	
12 <u>2-0</u>	
13 <u>3-0</u>	

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Length of stay in 1b <u>22 days</u>	c. CITY OR TOWN <u>Summersville</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>University of Missouri Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Blanche Jackson Bond</u>			4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1963</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</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>3-10-1905</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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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>Summersville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Charlie Jackson</u>		13b. MOTHER'S MAIDEN NAME <u>Letha Riley</u>		14. NAME OF HUSBAND OR WIFE <u>William Bond</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>University of Missouri Medical Records</u>	<u>Columbia, Missouri</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CESSATION OF RESPIRATION + PULSE.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
DUE TO (b) <u>ACUTE STEM CELL LEUKEMIA.</u>			
DUE TO (c) _____			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CRYPTOCOCCUS MENINGITIS, CA OF THE CERVIX.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)	
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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
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21. I attended the deceased from 4-26-63 to 5-18-63 and last saw her/him alive on 5-18-63
Death occurred at 9:05 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Sign or title) <u>John M. Laird, Jr. MD.</u>	22b. ADDRESS <u>MU Med Center</u>	22c. DATE SIGNED <u>5-18-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-20-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Summersville Missouri</u>
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24. FUNERAL DIRECTOR <u>DONCAN FUNERAL HOME</u>	ADDRESS <u>Mountain View Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>May 18, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF:

SHOULD READ:

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 12 1963

1010
-0501

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1

0-8
0-8

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 George A. Kerby

Licensed Embalmer No. 11952

P. O. Address Rollingwood, 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.