

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-019232**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 15-58 STATE FILE NUMBER

DO NOT WRITE ON THIS STUD.

AMENDED

**FILED MAY 21 1963**

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Butler</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Length of stay in lb <b>6 wks</b>	c. CITY OR TOWN <b>Hendrickson</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Doctors Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.R. # 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ARCHIE</b> Middle <b>AUSTIN</b> Last <b>FEARS</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/1892</b>
9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Ellington, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>JAMES C. FEARS</b>	
13b. MOTHER'S MAIDEN NAME <b>ELIZABETH BRADY</b>		14. NAME OF HUSBAND OR WIFE <b>MABLE FEARS.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. INFORMANT Address <b>29 Mrs. Mable Fears, Hendrickson, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b></b> 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) <b>Cystitis and Pyelitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b> <b>10 years</b>
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 <b></b> a.m. <b></b> p.m. <b></b>		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 <b></b> STATE <b></b>	
21. I attended the deceased from <b>Jan 29, 1954</b> to <b>May 3, 1963</b> and last saw <sup>her</sup> him alive on <b>May 3, 1963</b> Death occurred at <b>9:04 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert Chugelhardt MD</i> (Degree or title)		22b. ADDRESS <b>Poplar Bluff, Mo.</b>	22c. DATE SIGNED <b>5-7-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>5/5/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bernie</b>	23d. LOCATION (City, town, or county) <b>Bernie, Missouri.</b> (State)
24. FUNERAL DIRECTOR <b>Frank-Cotrell Chapel, Poplar Bluff, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>5/13/1963</b>	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59  
*16228*  
*20120*  
3  
4 *0*  
5 *1*  
6  
7 *0*  
8 *2*  
*94200*  
10  
11  
12 *2-0*  
13 *1-0*

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

*Charles E. Mung*

Licensed Embalmer No. 4877

P. O. Address Poplar Bluff, 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.