

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-019922

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 192 Primary Registration District No. 4231 Registrar's No. 25

STATE FILE NUMBER

FILED JUN 13 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain View</u>		Length of stay in 1b	c. CITY OR TOWN <u>Eminence</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>St. Francis Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>St. Francis Hospital</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gentry</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1963</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</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>11/21/85</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Shannon Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Joe Thomas</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Evaline Burns</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Paul Thomas Mountain View, 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>Acute myocardial infarction</u> DUE TO (b) <u>Anemia</u> DUE TO (c) <u>Duodenal ulcer - bleeding</u> Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 <u> </u> s.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>	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 <u> </u> STATE <u> </u>
21. I attended the deceased from <u>May 30</u> to <u>June 5</u> and last saw her/him alive on <u>June 5</u> Death occurred at <u>June 5, 1963</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M.C. Walton M.D.</u>		22b. ADDRESS <u>Mountain View, Mo.</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/8/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Eminence Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Eminence, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-10-1963</u>	26. REGISTRAR'S SIGNATURE <u>Charles D. Partain</u>

To Doctor: 11: A.M. 6/6/63

Rec'd from Dr. 4: P.M. 6/8/63

To Local Registrar 4: P.M. 6/8/63

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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 D. Portain

Licensed Embalmer No. 5107

P. O. Address Wm. V. Keene, 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.