

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration No. **FILED JUN 11 1963** Primary Registration District No. **4241** Registrar's No. **35** -63-020418
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 7000
2 7000

3
4 0
5 2
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7 1
8 9
9 4200

10
11
12 9000
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Oak Grove		Length of stay in 1b 18 years	c. CITY OR TOWN Oak Grove Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 103 N. Broadway		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 103 N. Broadway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hal Middle T Last Church		4. DATE OF DEATH Month 6 Day 7 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1888
9. AGE (last birthday) 75		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) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Indianapolis Ind
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Issac Church	
13b. MOTHER'S MAIDEN NAME Georgia Chamois		14. NAME OF HUSBAND OR WIFE Lillian Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Orna Lovett Lone Jack, Mo Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Heart Dis.			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) Jamaino - Curves undeveloped			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 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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 1947 to 6-7-1963 and last saw him alive on 6-6-1963 Death occurred at 11:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James W. Williams MD		22b. ADDRESS Oak Grove Mo	22c. DATE SIGNED 6-7-63
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE June 9 1963	23c. NAME OF CEMETERY OR CREMATORY Lone Jack Cem	23d. LOCATION (City, town, or county) (State) Lone Jack Mo
24. FUNERAL DIRECTOR Webb Funeral Home Oak Grove Mo		25. DATE RECD. BY LOCAL REG. 6-9-1963	26. REGISTRARS SIGNATURE D. B. Langford

USE BLACK INK OR TYPEWRITER RIBBON

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 William French

Licensed Embalmer No. 4737

P. O. Address Blue Springs 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.