

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022920

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 4503 Registrar's No. 43

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 11 1963

VS 300
Rev. 4/59

1 10:00
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Stoddard</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bernie</u> | | Length of stay in 1b | c. CITY OR TOWN <u>Bernie</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>Residence</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Residence</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Dona</u> Middle <u>Virginia</u> Last <u>Piatt</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>28</u> , Year <u>1963</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>3-17-1877</u> |
| 9. AGE (last birthday) <u>86</u> | | IF UNDER 1 YEAR Months <u>2</u> Days <u>17</u> | IF UNDER 24 HR Hours <u>11</u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired house-keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Bernie, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | 13a. FATHER'S NAME <u>Wm. T. Forville</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Lucy Smith</u> | | 14. NAME OF HUSBAND OR WIFE <u>William M. Piatt (Dec'd)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>no</u>) | | 17. INFORMANT <u>Lucille Piatt</u> Address <u>Bernie, 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>Cerebral Hemorrhage</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> |
| 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) <u>Senility</u> | | | 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>Nov. 2, 1962</u> to <u>May 27, 1963</u> and last saw her ^{him} alive on <u>May 27, 1963</u> Death occurred at <u>3:00 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>F. O. Kelley D. O.</u> (Degree or title) | | 22b. ADDRESS <u>Bernie, Missouri</u> | 22c. DATE SIGNED <u>5-29-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>5-30-63</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Bernie</u> | 23d. LOCATION (City, town, or county) (State) <u>Bernie, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Duffie-Rainey Funeral Home, Bernie, Mo.</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>5-31-63</u> | 26. REGISTRAR'S SIGNATURE <u>Velva V. Jenks</u> |

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

*Burial Permits
Issued 5/30/23
J.S.*

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 *Lucille Rainey*

Licensed Embalmer No. *4983*

P. O. Address *Depton, 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.