

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-023045

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **378** Primary Registration District No. **4552** Registrar's No. **26**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 27 1963

VS 300  
Rev. 4/59

1 **1141**

2 **1141**

3

4 **1**

5 **2**

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7 **1**

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9 **94201**

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11

12 **90-0**

13 **2-0**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Wright</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mountain Grove</b>		Length of stay in 1b <b>20 Years</b>	c. CITY OR TOWN <b>Mountain Grove</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>435 East South Street</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>435 East South Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED - First Middle Last <b>SADIE NAUGHT</b>			4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>82 Years</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: Months _____ Days _____ Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) <b>Anderson, Indiana</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James W. Summers</b>		13b. MOTHER'S MAIDEN NAME <b>Malinda Summers</b>	14. NAME OF HUSBAND OR WIFE <b>John Naught</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Roscoe Magers - Springfield, Mo</b>		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) <b>Coronary Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 few hrs</b>
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)			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 <b>May 6 - 1963 8:00 a.m.</b> to <b>May 6 - 63 11:20 a.m.</b> and last saw her alive on <b>May 6 - 1963</b> Death occurred at <b>11:15 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>P. W. Fleming M.D.</b>		22b. ADDRESS <b>W. Ave. Mo.</b>	22c. DATE SIGNED <b>5-10-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/9/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Mountain Grove, Missouri</b>
24. FUNERAL DIRECTOR <b>Barber Funeral Home - Mtn. Grove, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>5-23-1963</b>	26. REGISTRAR'S SIGNATURE <b>Bernard Silverman</b>

USE BLACK INK OR TYPEWRITER RIBBON

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This is to certify that the body of \_\_\_\_\_  
 deceased \_\_\_\_\_  
 was embalmed by \_\_\_\_\_  
 on the \_\_\_\_\_ day of \_\_\_\_\_  
 at \_\_\_\_\_  
 in the \_\_\_\_\_  
 county of \_\_\_\_\_  
 State of \_\_\_\_\_

**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 Bob Davis, Student Embalmer No. 678  
 working under my personal supervision.

Student Bob Davis  
Signature of Student Embalmer

Signed George Stapp

Licensed Embalmer No: 3161

P. O. Address Mt. Grove, MD

**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.

2011-83-0