

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-023946

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1039B

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 10 1963

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>1 week</u>	c. CITY OR TOWN <u>Nixa, Route #1</u>
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 Miles Southeast</u>
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Pearl</u> Last <u>McLean</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>	9. AGE (last birthday) <u>74</u>
13a. FATHER'S NAME <u>William Buxton</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Bates</u>	11. BIRTHPLACE (City and state or country) <u>Mound Valley, Kansas</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		14. SOCIAL SECURITY NO. <u>-</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</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 cardiorespiratory failure ^{Congestive thrombosis}</u>		17. INFORMANT <u>Mr. Otis McLean, Rte #1, Nixa, Missouri</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 or 10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Left hip fracture</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>fell at home</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <u>June 13, 63</u>	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.) <u>home-Nixa, Mo.</u>		20f. CITY, TOWN, OR LOCATION <u>Nixa</u>	COUNTY <u>Christian</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>13 June 63</u> to <u>20 June 63</u> and last saw her alive on <u>19 June 63</u> Death occurred at <u>5:30</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Erin M. Dillard, M.D.</u> (Degree or title)		22b. ADDRESS <u>307 Professional Building Springfield, Missouri</u>	22c. DATE SIGNED <u>6/27/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 22, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Selmore Cemetery</u>	23d. LOCATION (City, town, or county) <u>Route #1, Ozark, Missouri</u>
24. FUNERAL DIRECTOR <u>J. Alan Harris</u> ADDRESS <u>Ozark, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-8-63</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

JUL 11 1963

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 _____

Mean Harris

Licensed Embalmer No. 4390

P. O. Address Ozark, 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.