

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-027355**

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **925**

STATE FILE NUMBER

**FILED AUG 5 1963**

|   |                               |  |                                   |  |                                |
|---|-------------------------------|--|-----------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>  |                                   |  |                                |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>   |                               | Length of stay in 1b <b>24 yrs</b>   |                                   | c. CITY OR TOWN <b>St. Joseph</b>  |                                |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Methodist Hospital</b>   |                               | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                                   | d. STREET ADDRESS (If outside, give location) <b>1810 Savannah Ave.</b>  |                                |
| 3. NAME OF DECEASED (Type or print) <b>LAURA ALICE PREWITT</b>  |                               | First Middle Last  |                                   | 4. DATE OF DEATH Month <b>July</b> Day <b>28</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>4/27/1881</b> | 9. AGE (last birthday) <b>82</b>   | IF UNDER 1 YEAR IF UNDER 24 HR |
| 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 <b>Home</b>  |                                   | 11. BIRTHPLACE (City and state or country) <b>Montrose Missouri</b>  |                                |
| 12. CITIZEN OF WHAT COUNTRY <b>U S A</b>  |                               | 13a. FATHER'S NAME <b>Joseph Tyree</b>   |                                   | 13b. MOTHER'S MAIDEN NAME <b>Susan Atchly</b>  |                                |
| 14. NAME OF HUSBAND OR WIFE <b>Deceased</b>   |                               | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>   |                                   | 16. SOCIAL SECURITY NO. <b>[REDACTED]</b>  |                                |
| 17. INFORMANT Address <b>Mrs. Carl Symes Savannah, Mo.</b>  |                               | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                   | INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b><br><b>Unknown</b>   |                                |
| 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.<br><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.  |                               | 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 <b>7/26/63</b> to <b>7/28/63</b> and last saw her alive on <b>7/28/63</b><br>Death occurred at <b>11:40 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |                               |  |                                   |  |                                |
| 22a. SIGNATURE (Degree or title) <b>[Signature]</b>   |                               | 22b. ADDRESS <b>SOCIAL WELFARE BOARD 10th &amp; Olive, St. Joseph, Mo.</b>   |                                   | 22c. DATE SIGNED <b>7/29/63</b>  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |                               | 23b. DATE <b>7/29/63</b>   |                                   | 23c. NAME OF CEMETERY OR CREMATORY <b>Montrose Cemetery</b>  |                                |
| 23d. LOCATION (City, town, or county) <b>Montrose Missouri</b>  |                               | 23e. FUNERAL DIRECTOR <b>[Signature]</b> ADDRESS <b>St. Joseph, Mo.</b>  |                                   | 25. DATE RECD. BY LOCAL REG. <b>July 31, 1963</b>  |                                |
| 26. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                               |  |                                   |  |                                |

DO NOT WRITE ON THIS STUB  
 AMENDED  
 VS 300 Rev. 4/59  
 1 5117  
 2 5117  
 3 2  
 4 1  
 5 2  
 6  
 7 0  
 8 2  
 9 4200  
 10  
 11  
 12 2-0  
 13 10  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 SHOULD READ  
 ITEM NO.  
 BY AFFIDAVIT OF **[Signature]** MEDICAL CERTIFICATION  
 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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph 1720

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.

Permit issued 7-28-63

108 69

0 - 28