

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027462

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 46 Primary Registration District No. 4063 Registrar's No. 37

FILED AUG 12 1963

VS 300  
Rev. 4/59  
1 0130  
2 0251  
3  
4 0  
5 2  
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7 0  
8 2  
9 420.1  
10  
11  
12 90-0  
13 2-0

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 <b>Caldwell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hamilton</b>		Length of stay in 1b <b>9 mo.</b>	c. CITY OR TOWN <b>Cameron</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>Home Of Son.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>106 so. Orange</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alphonse Routh Reece</b>			4. DATE OF DEATH Month Day Year <b>July 24 1963</b>
5. SEX <b>Male</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>Jan. 13 1875</b>
9. AGE (last birthday) <b>88 yr 8</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Headville, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			
13a. FATHER'S NAME <b>William S. Reece</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy C. Jones</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	17. INFORMANT Address <b>Sons</b>
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Stenosis</b> DUE TO (b) <b>Arterio-Sclerotic Heart Disease</b> DUE TO (c) CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>sudden death</b> <b>7 years</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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <b>First visit</b> to _____ and last saw him alive on _____ Death occurred at <b>6:30</b> A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Herbert R. Booth</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>Hamilton, Missouri</b>	22c. DATE SIGNED <b>7/25/63.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 26 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ogan, Meadville Mo.</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>Poland Funeral Home, Cameron, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Aug 5, 63</b>	26. REGISTRAR'S SIGNATURE <b>Gladys Jones</b>

USE BLACK INK OR TYPEWRITER RIBBON

STATE-10-10-10

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**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 Robert F. Poland

Licensed Embalmer No. 4777

P. O. Address Camden 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.

*embalmed by Robert F. Poland*