

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027476

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 233

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 12 1963

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>1 Mo.</u>	c. CITY OR TOWN <u>Mokane</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Mem. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>none</u> (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>Doiman</u> Last <u>Doiman</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1963</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>8/26/1888</u>		AGE (last birthday) <u>74</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>Home</u>		11. BIRTHPLACE (City and state or country) <u>Jebbetts, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>

13a. FATHER'S NAME <u>George Ewens</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Jones</u>		14. NAME OF HUSBAND OR WIFE <u>John W.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>S. C. Doiman</u> Address <u>Mokane, 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>Terminal Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Ch. myocarditis with congestive failure</u>		<u>2-3 weeks</u>
DUE TO (c) <u>generalized arteriosclerosis</u>		<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>diabetic mellitus, mild</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 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 <u>[blank]</u> a.m. <u>[blank]</u> 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>5/11/63</u> to <u>8/1/63</u> and last saw her <u>alive</u> on <u>8/1/63</u> Death occurred at <u>7:45</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Nancy D. M.D.</u>	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>8/3/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/4/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Callaway Mem. Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton, Mo.</u>
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24. FUNERAL DIRECTOR <u>Maupin Funeral Home</u>	ADDRESS <u>Fulton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 6 - 1963</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
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 USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

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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 Gene C. Gaupier

Licensed Embalmer No. 5092

P. O. Address Fulton, 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.