

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029138

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 180

FILED AUG 7 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY LIVINGSTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY LIVINGSTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE		Length of stay in 1b 54 YEARS	c. CITY OR TOWN CHILLICOTHE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 915 ANN ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle MOZENA Last MEAD			4. DATE OF DEATH Month AUGUST Day 4 Year 1963
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/27/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (last birthday) 88 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Hours Min.
13a. FATHER'S NAME JOEL SIMMONS		13b. MOTHER'S MAIDEN NAME CLARA ELLEN WEBB	12. CITIZEN OF WHAT COUNTRY U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT MISS GRACE SIMMONS Address 915 ANN ST. CHILLICOTHE, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterial sclerosis 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH 5 min 5 years
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 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>Jan. 15-56</u> to <u>Aug 4-63</u> and last saw her alive on <u>Aug 3-63</u> Death occurred at <u>8:00</u> A.M. on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Joseph P. Conrad M.D.</i>		22b. ADDRESS 511 Elm St., Chillicothe, Mo.	22c. DATE SIGNED 8/5/63
24. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/6/63	23a. NAME OF CEMETERY OR CREMATORY BLUEMOUND CEMETERY	23d. LOCATION (City, town, or county) (State) BLUEMOUND, MISSOURI
24. FUNERAL DIRECTOR NORMAN FUNERAL HOME: CHILLICOTHE, MO.		25. DATE RECD. BY LOCAL REG. <u>Aug 5, 1963</u>	26. REGISTRAR'S SIGNATURE <i>Annalee Taylor</i>

821050-101

Date Taken to Dr. Conrad 8/5/63
Date Rec'd. from Dr. Conrad 8/6/63

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 Elton Norman

Licensed Embalmer No. 4036

P. O. Address CHILLICOTHE, MISSOURI

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.