

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-031017**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 391 Primary Registration District No. 4515 Registrar's No. 68

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 12 1963**

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SULLIVAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN MO</u>		c. CITY OR TOWN <u>MILAN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SULLIVAN CO. MEMORIAL HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>RURAL</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM RAYMOND QUIGLEY</u>		4. DATE OF DEATH Month Day Year <u>JULY 31 1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>7-17-88</u>
9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GEN FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>MILAN MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>JAMES PRESTON QUIGLEY</u>	
13b. MOTHER'S MAIDEN NAME <u>AMANDA M SEARS</u>		14. NAME OF HUSBAND OR WIFE <u>EVELYN QUIGLEY</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>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>MRS EVELYN QUIGLEY MILAN MO</u>		Address	
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>Cerebral accident</u> DUE TO (b) <u>arteriosclerosis.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
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 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>July 20</u> to <u>July 31</u> and last saw him alive on <u>9-31-63</u> Death occurred at <u>11:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>Milou</u>	
22c. DATE SIGNED <u>8-2-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>AUG 2, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>	23d. LOCATION (City, town, or county) (State) <u>Matamoras MO</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>[Address]</u>	25. DATE RECD. BY LOCAL REG. <u>8-5-63</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>

VS 300  
Rev. 4/59  
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DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Samuel Hagen*

Licensed Embalmer No. 3792  
P. O. Address *Weldon Ms*

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.