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MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 5505 Registrar's No. 226 STATE FILE NUMBER 63-032059

FILED SEP 3 1963

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Rev. 4/59
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DATE AMENDED
INSTEAD OF
DOCUMENT
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
SHOULD READ
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>HENRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>HENRY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOGARD</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>NEAR URICH</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>AT Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NOAH</u> Middle <u>OBEDIAH</u> Last <u>REDFORD</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>31</u> Year <u>1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>12/6/1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	9. AGE (last birthday) <u>73</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11. BIRTHPLACE (City and state or country) <u>NEAR URICH Henry U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>NOAH REDFORD</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE NORRIS</u>	14. NAME OF HUSBAND OR WIFE <u>EMMA REDFORD</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Shade Helms</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>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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>12-20-57</u> to <u>8-26-63</u> and last saw him alive on <u>8-26-63</u> Death occurred at <u>2:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. J. Brown, M.D.</u>		22b. ADDRESS <u>Clinton, Mo.</u>	22c. DATE SIGNED <u>8-31-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Sept 24 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Urich Cemetery</u>	23d. LOCATION (City, town, or county) <u>near Urich Mo</u> (State)
24. FUNERAL DIRECTOR ADDRESS <u>W. J. Brown Urich Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-31-63</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

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 A. R. Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton 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.

Permit Obtained
8/3/63
MAE