

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032799

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. ~~5554~~ <sup>176</sup> Primary Registration District No. ~~110~~ <sup>5654</sup> Registrar's No. 15 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

**FILED AUG 26 1963**

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Miller</u>		Length of stay in 1b <u>Native</u>	c. CITY OR TOWN <u>Miller</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>West Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Clyde Marsh Temple</u>			4. DATE OF DEATH Month Day Year <u>8-14-1963</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>9-23-1895</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>10 22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Post master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawrence Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>P. C. Temple</u>		13b. MOTHER'S MAIDEN NAME <u>May Marsh</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie Temple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>			16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>Bessie Temple Miller Mo.</u> Address

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute circulatory failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>massive myocardial infarction immediate</u>		
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 April 1963 to \_\_\_\_\_ and last saw <sup>her</sup> him alive on April 1963  
Death occurred at 4:30 8 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Hugh Baker M.D.</u>	22b. ADDRESS <u>Miller, Mo.</u>	22c. DATE SIGNED <u>8-16-63</u>
---	---------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-18-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pheasant Grove</u>	23d. LOCATION (City, town, or county) (State) <u>So. of Miller, Mo.</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Morris Simon Miller Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-18-1963</u>	26. REGISTRAR'S SIGNATURE <u>H. S. Burney</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59

1 0550

2 0550

3

4 0

5 1

6

7 0

8 2

94201

10

11

12 90-2

13 20

DATE AMENDED

2

2

2

2

2

2

2

2

2

2

2

2

2

2

2

000000-0000

W/O M  
T. C. M.

AUG 28 1963

**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 E. R. Lerman

Licensed Embalmer No. 3297

P. O. Address Miller 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.