

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033021

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 240 Primary Registration District No. 5825 Registrar's No. 36

FILED AUG 26 1963

VS 300
Rev. 4/59

1 0720

2 0720

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4 3

5 0

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9 571.0

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11

12 90-0

13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>NEW MADRID</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>NEW MADRID</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Como</u>		Length of stay in 1b	c. CITY OR TOWN <u>Como</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>none</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt#1 CATRON</u>
3. NAME OF DECEASED (Type or print) First <u>SUE</u> Middle <u>CARTER</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>about 6/3/69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Como Mo.</u>
13a. FATHER'S NAME <u>T. J. CARTER</u>		13b. MOTHER'S MAIDEN NAME <u>MARIE TREVY</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</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.	17. INFORMANT <u>T. J. CARTER, Como, Mo. Rt#1</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO (b) <u>Gastroenteritis</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>4 1/2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prematurity</u>			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>8/15/63</u> to _____ and last saw her alive on <u>8/15/63</u> Death occurred at <u>8/16/63 3 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Daniel R. Fenwick MD</u>		22b. ADDRESS <u>Jel. Bowen Mo.</u>	22c. DATE SIGNED (State) <u>8/16/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8/16/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Simmons PARK</u>	23d. LOCATION (City, town, or county) <u>NEAR CATRON, MO.</u>
24. FUNERAL DIRECTOR <u>None, T. J. CARTER, Rt#1, Como, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-16-63</u>	26. REGISTRAR'S SIGNATURE <u>Chas. Luper by J. L. Pender</u>

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.