

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033051
STATE FILE NUMBER

Registration District No. 245 Primary Registration District No. 3047 Registrar's No. 120

DO NOT WRITE ON THIS STUB

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF DOCUMENT

FILED SEP 10 1963					
1. PLACE OF DEATH					
a. COUNTY <u>Newton</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Neosho</u> Length of stay in lb <u>1 day</u>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sale Memorial</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. STATE <u>Missouri</u> COUNTY <u>McDONALD</u>					
c. CITY OR TOWN <u>Anderson</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 Middle Last			4. DATE OF DEATH Month Day Year		
<u>Donnie Everett Thomas</u>			<u>Sept. 3 1963</u>		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR
<u>MALE</u>	<u>WHITE</u>		<u>7-3-1944</u>	<u>19</u>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
<u>Service Station</u>		<u>Gas</u>		<u>Stella, Mo.</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
<u>Ernest Thomas</u>		<u>Thelma Meeks</u>		<u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
<u>No</u>				<u>Ross Thomas Anderson, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Sacceration of Brain</u>					
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)					
<u>Basal skull fracture</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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>12:15</u> Day <u>Sept 3, '63</u> Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3 Sept 63</u> to <u>3 Sept 63</u> and last saw her alive on <u>3 Sept 63</u>		Death occurred at <u>5:46 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George C Olive, M.D.</u>			22b. ADDRESS <u>Neosho, Mo</u>		22c. DATE SIGNED <u>9-4-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Sept. 6, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Neosho Memorial</u>	
24. FUNERAL DIRECTOR <u>Roller Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>9-5-63</u>		26. REGISTRAR'S SIGNATURE <u>Marydene Belka</u>	
<u>Anderson, Mo.</u>		(Licensed Embalmer's Statement on Reverse Side)			

USE BLACK INK OR TYPEWRITER RIBBON

By J. Hubbard Deputy

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 Robert C. Keller

Licensed Embalmer No. 5062

P. O. Address Andover, 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.