

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033362

Registration District No. 316 Primary Registration District No. 4462 Registrar's No. 365 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10940

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

FILLED SEP 12 1963	
1. PLACE OF DEATH a. COUNTY St. Francois	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Elvins, Route 1 Length of stay in Tb 11 years	
c. CITY OR TOWN Elvins, Routel Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS (if outside, give location) Home Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cleveland Middle Outland Last Outland	
4. DATE OF DEATH Month September Day 2 Year 1963	
5. SEX Male	6. COLOR OR RACE White
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1885
9. AGE (last birthday) 77	
IF UNDER 1 YEAR Months 9 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Orderly	
10b. KIND OF BUSINESS OR INDUSTRY Alexian Bro's	
11. BIRTHPLACE (City and state or country) Pomona, Illinois	
12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME (Unknown) Outland	
13b. MOTHER'S MAIDEN NAME Ann Knight	
14. NAME OF HUSBAND OR WIFE Gertick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of war) No	
16. SOCIAL SECURITY NO. 5	
17. INFORMANT Address Gertick Outland, Elvins, Route 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension DUE TO (c) Arterio sclerosis 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 Bismarck, Mo COUNTY Missouri STATE Mo	
21. I attended the deceased from 8/31/63 to 9/2/63 and last saw him alive on 9/1/63 Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) James E. Wester M.D.	
22b. ADDRESS Bismarck, Mo	
22c. DATE SIGNED 9/5/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 9-5-1963	
23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	
23d. LOCATION (City, town, or county) Bismarck, Missouri	
24. FUNERAL DIRECTOR ADDRESS Shipman & Sons, Bismarck, Mo.	
25. DATE RECD. BY LOCAL REG. Sept 5, 1963	
26. REGISTRAR'S SIGNATURE Etheridge	

USE BLACK INK OR TYPEWRITER RIBBON

SEP 13 1963
OCT 2 1963
NOV 5 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 *J. Jimmy Dipina*

Licensed Embalmer No. 5223

P. O. Address Bismarck, Me

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.

[Faint handwritten notes at the bottom of the page]