

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035294  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 283

FILED OCT 8 1963

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>5 Months</u>	c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. No. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>552 Flora</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Chambers</u>			4. DATE OF DEATH Month: <u>9/</u> Day: <u>30</u> Year: <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/21/1909</u>
9. AGE (last birthday) <u>53</u>		IF UNDER 1 YEAR Months: Days: Hours: Min.	IF UNDER 24 HR Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office - housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Frederick Steven Roberts</u>	
13b. MOTHER'S MAIDEN NAME <u>Alice Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>State Hosp. Records Fulton, Mo</u> Address:
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY... IMMEDIATE CAUSE (a) <u>Fibrinol purulent peritonitis</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>Carcinoma of the duodenum and hepatic flexure (?)</u>			
DUE TO (c) <u>Lungs - bronchopneumonia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Lungs - bronchopneumonia</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 checked="" type="checkbox"/> NO <input 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: 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. <input checked="" type="checkbox"/> attended the deceased from <u>State Hosp. # 1</u> <u>4/29/63</u> to <u>9/30/63</u> Death occurred at <u>2:30</u> <u>p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>9/30/63</u>	
22a. SIGNATURE <u>Frederick P. Handler MD</u> (Degree or title)		22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/2/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Champaign Ill</u>
24. FUNERAL DIRECTOR <u>Smith Funeral Home - Hannibal Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Sept. 30, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</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 John Swan

Licensed Embalmer No. 4540

P. O. Address Humboldt 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.