

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-235509

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 360

<b>FILED SEP 19 1963</b>	
1. PLACE OF DEATH a. COUNTY <u>Cole</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u> Length of stay in 1b <u>2 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STILL HOSPITAL</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>Mo.</u> b. COUNTY <u>Cole</u> c. CITY OR TOWN <u>Russellville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Russellville</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First- <u>Teresa</u> Middle- <u>Sue</u> Last- <u>BALL</u>			4. DATE OF DEATH Month <u>September</u> Day <u>15</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 type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 13 1963</u>	9. AGE (last birthday) Months <u>2</u> Days <u>2</u> Hours <u></u> Min. <u></u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Jefferson City Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>CLARENCE BALL</u>		13b. MOTHER'S MAIDEN NAME <u>Bernice Whitaker</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No</u> )			16. SOCIAL SECURITY NO. <u>[Redacted]</u>		17. INFORMANT Address <u>CLARENCE BALL Russellville Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYALINE DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)			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 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		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 9-13-63 to 9-15-63 and last saw her alive on 9-15-63  
 Death occurred at 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>E.M. Eberhart D.O.</u>		22b. ADDRESS <u>Russellville</u>		22c. DATE SIGNED <u>9-16-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Removal</u>	23b. DATE <u>SEPT 17, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Outside Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>ARROLL, Mo.</u>
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24. FUNERAL DIRECTOR <u>Scriver-Steverson</u>	ADDRESS <u>Russellville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>16 September 1963</u>	26. REGISTRAR'S SIGNATURE <u>Theresa E. Richter</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300  
Rev. 4/59  
10269  
20260  
3  
4 1  
5 0  
6  
7 0  
8 0  
9773.0  
10  
11  
121-2  
133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 James R. Scenic

Licensed Embalmer No. 4880

P. O. Address Uxmal, Md.

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.