

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-035724**

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1283-A

DO NOT WRITE ON THIS SUB

AMENDED

**FILED SEP 25 1963**

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wetzel</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>1 hr. 8 min.</u>	c. CITY OR TOWN <u>Elkland</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Drs' Memorial Hospital, Inc.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>Ellen</u> Last <u>Bone</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (last birthday) <u>67</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ 11. BIRTHPLACE (City and state or country) <u>Dallas Co., Missouri</u> 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>G. W. Bone</u>		13b. MOTHER'S MAIDEN NAME <u>May Roddy</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. _____ 17. INFORMANT <u>Sister</u> Address <u>Miss Willie Bone - Rt. 2 - Elkland, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> DUE TO (b) <u>Decompensated Hypertensive Heart Disease</u> DUE TO (c) <u>Chronic Glomerulonephritis (Cause unknown)</u> 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 _____ 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>9-17-63 11:30 am</u> to <u>9-17-63</u> and last saw her/him alive on <u>9-17-63</u> Death occurred at <u>9-17-63 12:38 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>Deland E. Wetzel D.O.</u>		22b. ADDRESS <u>700 E. Sunshine - Springfield, Mo.</u>	
22c. DATE SIGNED <u>9-17-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-19-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>		23d. LOCATION (City, town, or county) <u>Buffalo, Missouri</u>	
24. FUNERAL DIRECTOR <u>Jones-Cantlon</u> ADDRESS <u>Buffalo, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-23-63</u>	
		26. REGISTRAR'S SIGNATURE <u>Bernice Medley</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 INSTEAD OF

VS 300 Rev. 4/59  
 10397  
 21120  
 3  
 4 1  
 5 0  
 6  
 7 0  
 8 0  
 9592X  
 10  
 11  
 12 3-2  
 13

USE BLACK INK OR TYPEWRITER RIBBON

9-17-63

**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 Jerry J. Cantlon

Licensed Embalmer No. 5153

P. O. Address Buffalo, 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.