

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038711

STATE FILE NUMBER

Registration District No. 6251 Primary Registration District No. 370 Registrar's No. 115

FILED SEP 23 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1110

2 1110

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>WAYNE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WAYNE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>GREENVILLE (KIME ROUTE)</u> Length of stay in 1b		c. CITY OR TOWN <u>GREENVILLE MO.</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>GREENVILLE ROUTE KIME</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RED ROUTE KIME</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EVE E MOTT</u>			4. DATE OF DEATH Month Day Year <u>SEPT. 16 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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1883</u>
9. AGE (last birthday) <u>79-7-17</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME WORK</u>	11. BIRTHPLACE (City and state or country) <u>FAIRBAULT, MINN.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>WILLIAM HALL</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JESSE MOTT (DECEASED)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of serv) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT Address <u>Dorothy Schalky Greenville 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>Alzheimers</u> DUE TO (b) <u>[redacted]</u> DUE TO (c) <u>[redacted]</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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	COUNTY	STATE
21. I attended the deceased from <u>15 Sept</u> to <u>16</u> and last saw her/him alive on <u>15 Sept</u> . Death occurred at <u>3:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. Myers M.D.</u>		22b. ADDRESS <u>Colwater Mo</u>	22c. DATE SIGNED <u>9/17/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>SEPT 17 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DONNYBROOK</u>	23d. LOCATION (City, town, or county) (State) <u>KEN MARE N. DAKOTA</u>
24. FUNERAL DIRECTOR <u>GISH FUNERAL HOME PIEDMONT, MO</u> ADDRESS <u>321 N. MAIN</u>		25. DATE RECD. BY LOCAL REG. <u>9-17-63</u>	26. REGISTRAR'S SIGNATURE <u>Bretta M. Ward</u>

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.