

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1452 63-029541
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in lb 6 DAYS	c. CITY OR TOWN MARSHFIELD
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST HOSP		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4 MI SOUTH
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTIAN Lewis BINTZ		4. DATE OF DEATH Month Day Year OCT 21 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 6-3-1898
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 65
10a. FATHER'S NAME LOWIE BINTZ		10b. MOTHER'S MAIDEN NAME GENEVA SUTHERS	11. BIRTHPLACE (City and state or country) MISSOURI
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. NAME OF INFORMANT MARY BINTZ		14. NAME OF HUSBAND OR WIFE MARY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. ADDRESS MARSHFIELD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO (b) lung disease of undetermined type DUE TO (c) _____ 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) ASHD E myocardial infarction			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 Dec. 1962 to 10-21-63 and last saw her alive on 10-21-63 Death occurred at 11 25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Roll. E. Asafflebaum M.D.	
22b. ADDRESS Springfield, Mo.		22c. DATE SIGNED 10-24-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD	23d. LOCATION (City, town, or county) (State) MARSHFIELD MO
24. FUNERAL DIRECTOR BARBER-EDWARDS, MARSHFIELD		25. DATE RECD. BY LOCAL REG. 10-25-63	26. REGISTRAR'S SIGNATURE Lorraine Medley

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 George Stapp

Licensed Embalmer No. 3/6

R. O. Address Mr. E. W. W.

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. _____

R. O. Address _____

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working under my personal supervision.

Student _____ Signature of Student Embalmer _____

Signed _____

Licensed Embalmer No. _____

R. O. Address _____

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Signed _____

Licensed Embalmer No. _____

R. O. Address _____

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Signed _____

Licensed Embalmer No. _____

R. O. Address _____

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or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____ Signature of Student Embalmer _____

Signed _____

Licensed Embalmer No. _____

R. O. Address _____

11/21/63

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.

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. _____

R. O. Address _____