

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040394

STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 209

DO NOT WRITE ON THIS STUB

AMENDED

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| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT | MEDICAL CERTIFICATION | BY AFFIDAVIT OF |
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FILLED OCT 22 1963

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| 1. PLACE OF DEATH a. COUNTY JASPER | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CARTHAGE | | Length of stay in 1b 20 YEARS | c. CITY OR TOWN CARTHAGE |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MCCUNE BROOKS HOSPITAL | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 705 OLIVE STREET |
| 3. NAME OF DECEASED (Type or print) First MAUD Middle MABLE Last SYLVESTER | | 4. DATE OF DEATH Month OCTOBER Day 16 , Year 1963 | |
| 5. SEX FEMALE | 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 8-23-1880 |
| 9. AGE (last birthday) 83 | | 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) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | 11. BIRTHPLACE (City and state or country) COOPER COUNTY, Mo. |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME JOSEPH S. FRANKLIN | |
| 13b. MOTHER'S MAIDEN NAME MATTIE SMITH | | 14. NAME OF HUSBAND OR WIFE LEMUEL P. SYLVESTER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No | | 16. SOCIAL SECURITY NO. [REDACTED] | |
| 17. INFORMANT I. E. SYLVESTER, RT 2, CARTHAGE, Mo. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage Cerebral | | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension | | | |
| DUE TO (c) Arteriosclerosis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Oct 11, '63 to Oct 16, '63 and last saw her alive on Oct 16, '63 Death occurred at 4:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE George H. Wood (degree or title) | | 22b. ADDRESS M.D. 1515 HAZEL, CARTHAGE, Mo. | |
| 22c. DATE SIGNED 10-17-63 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL-BURIAL | | 23b. DATE 10-19-63 | 23c. NAME OF CEMETERY OR CREMATORY INDEPENDENCE CEMETERY |
| 23d. LOCATION (City, town, or county) BATES COUNTY, MISSOURI | | (State) | |
| 24. FUNERAL DIRECTOR ULMER FUNERAL HOME, CARTHAGE, Mo. | | 25. DATE RECD. BY LOCAL REG. 10-19-63 | 26. REGISTRAR'S SIGNATURE [Signature] |

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 _____

Melvin Garrett

Licensed Embalmer No. 5121

P. O. Address CARTHAGE, 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.