

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-043439**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 120 Primary Registration District No. 5444 Registrar's No. 106

**FILED NOV 19 1963**

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Gentry</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Athens Twp.</u>		c. CITY OR TOWN <u>Athens Twp.</u>	
Length of stay in 1b <u>lifetime</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>S.E. of Albany</u>		d. STREET ADDRESS (If outside, give location) <u>S.E. of Albany</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <u>Amanda</u> Middle <u>Margaret</u> Last <u>Brown</u>			Month <u>November</u> Day <u>7</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (last birthday) <u>90</u>
11a. FATHER'S NAME <u>Zeph Spiers</u>		11b. MOTHER'S MAIDEN NAME <u>Martha Vance</u>	11. BIRTHPLACE (City and state or country) <u>Gentry Co. Missouri</u>
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <u>Thomas O. Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT Address <u>Mr. Newton Brown McFall, Missouri</u>
18. CAUSE OF DEATH (Enter only one cause per line)			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Malnutrition &amp; debility</u>			
DUE TO (b) <u>Metastatic carcinoma</u>			
DUE TO (c) <u>Carcinoma of uterus</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 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 <u>[blank]</u> a.m. <u>[blank]</u> 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>October 1, 1963</u> , to <u>Nov. 7, 1963</u> and last saw her <sup>her</sup> alive on <u>Oct. 19, 1963</u>		Death occurred at <u>8:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Howard A. Smith</u> (Degree or title)		22b. ADDRESS <u>Albany, Missouri</u>	22c. DATE SIGNED <u>Nov 8, 1963</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11/10/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McFall</u>	23d. LOCATION (City, town, or county) (State) <u>McFall Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Brooks-Cochell Funeral Home, Albany, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-11-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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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

**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 me \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donald E Cochell

Licensed Embalmer No. 4868

P. O. Address Albany, 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.