

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

68-044643
STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 3099 Registrar's No. Voy

DO NOT WRITE ON THIS STUB
AMENDED

VS 300 Rev. 4/59	DATE AMENDED
1 0591	
2 0520	
3	
4 1	
5 1	
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7 0	
8 0	
9 443XH	
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11	
12 4-0	
13 2-0	

FILED DEC 5 1963	
1. PLACE OF DEATH a. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>MARCELINE</u>	
Length of stay in 1b <u>1 HR.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CHARITON</u>	
c. CITY OR TOWN <u>MARCELINE</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>RFD 2</u>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VERNA</u> Middle <u>B.</u> Last <u>PEDEN</u>	
4. DATE OF DEATH Month <u>NOV.</u> Day <u>23</u> Year <u>1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-1911</u>
9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>
11. BIRTHPLACE (City and state or country) <u>ETHEL Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>John White</u>	13b. MOTHER'S MAIDEN NAME <u>SUSAN WHISENAND</u>
14. NAME OF HUSBAND OR WIFE <u>FRED PEDEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NO</u>
17. INFORMANT Address <u>Mo.</u> <u>FRED PEDEN MARCELINE</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>	
DUE TO (b) <u>Supratentorial Cardiovascular Disease</u>	
DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Adenocarcinoma of thyroid</u>	
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 _____ s.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>11:30 PM</u> to _____ and last saw her ^{her} alive on <u>11-23-63</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>George J. [Signature]</u> (Degree or title)	22b. ADDRESS <u>Marceline, Mo.</u>
22c. DATE SIGNED <u>11-25-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-25-63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem</u>	23d. LOCATION (City, town, or county) (State) <u>MARCELINE Mo.</u>
24. FUNERAL DIRECTOR <u>MILLER-Tillotson</u>	25. DATE RECD. BY LOCAL REG. <u>11-24-63</u>
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

MEDICAL CERTIFICATION DOCUMENT BY AFFIDAVIT OF

JAN 28 1964

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 Libbun K. Tidatson

Licensed Embalmer No. 4508

P. O. Address Marceline
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.