

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-044683

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 195 Primary Registration District No. 5711 Registrar's No. 62-62 STATE FILE NUMBER

FILED DEC 3 1963

VS 300
Rev. 4/59

1 0600
2 0600
3
4 1
5 2
6
7 1
8 2
9 1341
10
11
12 90-0
13 1-0

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>McDONALD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDONALD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Elkhorn Township</u>		Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>Anderson</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route 3 Anderson</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 3</u>
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>Mauda</u> Last <u>Despain</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>28</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>6-18-1885</u>
9. AGE (last birthday) <u>78</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Making</u>	11. BIRTHPLACE (City and state or country) <u>Penno County, Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</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. [Redacted]	17. INFORMANT <u>Mrs. Zona Compton Anderson, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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>Jan 1963</u> to <u>Nov 28</u> and last saw her <u>live</u> on <u>Nov 23, 1963</u> Death occurred at <u>5:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Neosho Mo</u>	22c. DATE SIGNED <u>11-29-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-1-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE</u>	23d. LOCATION (City, town, or county) (State) <u>GATE OKLA.</u>
24. FUNERAL DIRECTOR <u>Parker Funeral Home</u> <u>Anderson, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-30-63</u>	26. REGISTRAR'S SIGNATURE <u>Mary A. Bradley</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 Robert C. Kallh

Licensed Embalmer No. 5062

P. O. Address Andover, Ma

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.

REMOVED PERMIT ISSUED NOV-22-63