

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1421

63-047066
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

FILED DEC 18 1963

VS 300
Rev. 4/59

15117

26001

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

C. Smith, MD

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri ; COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 23 years	c. CITY OR TOWN Excelsior Springs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 719 Kennedy Avenue
3. NAME OF DECEASED (Type or print) First Clara Middle May Last Courtney			4. DATE OF DEATH Month December Day 13 Year 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct., 1880
9. AGE (last birthday) 83 yrs.		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 Own Home	11. BIRTHPLACE (City and state or country) Kentucky
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Joseph Russell	
13b. MOTHER'S MAIDEN NAME Mary Yokum		14. NAME OF HUSBAND OR WIFE Edward F. Courtney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Records of State Hospital #2		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency			INTERVAL BETWEEN ONSET AND DEATH 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Broncho Pneumonia			3 days
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 6-1-61 to 12-13-63 and last saw her alive on 12-13-63		Death occurred at 1:40 P. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Deceased or Affiant) <i>C. Smith M.D.</i>		22b. ADDRESS State Hospital #2	22c. DATE SIGNED 12-13-63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	Dec. 13, 1963	Pasley Funeral Home	Liberty, Missouri
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 17, 1963	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>

INDIANA BOARD OF HEALTH

STATE OF INDIANA

Permit issued 12-13-63

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 Edward R. Harrington

Licensed Embalmer No. 3208

P. O. Address St. Joseph, 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.