

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048411

STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 216

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10495
20495
3
4 1
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED DEC 30 1963			
1. PLACE OF DEATH a. COUNTY <u>Jasper</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webb City</u> Length of stay in 1b <u>45 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jane Chinn Hospital</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>Missouri</u> b. COUNTY <u>Jasper</u> c. CITY OR TOWN <u>Webb City,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>536 S. Hall St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Ellen</u> Last <u>Daugherty</u>			
4. DATE OF DEATH <u>December 27, 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>9-10-1880</u>
9. AGE (last birthday) <u>83</u>		9. AGE (last birthday) <u>83</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	
11. BIRTHPLACE (City and state or country) <u>Pocahontas, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Mordaci Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Reeder</u>	
14. NAME OF HUSBAND OR WIFE		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Address</u> Address <u>306 N. Liberty St. Webb City, Mo.</u>		17. INFORMANT Address <u>Mary Address 306 N. Liberty St. Webb City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage.</u> DUE TO (b) <u>Idiopathic hemorrhagic purpura.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>27 days</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 _____ 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.) <u>II-II-50</u>		20f. CITY, TOWN, OR LOCATION <u>Webb City</u> COUNTY _____ STATE _____	
21. I attended the deceased from <u>11-11-63</u> to <u>12-27-63</u> and last saw her/him alive on <u>12-27-63</u> Death occurred at <u>2:45A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. W. Fisher</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Webb City, Missouri</u>	
22c. DATE SIGNED <u>12-27-63</u>		22c. DATE SIGNED <u>12-27-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-30-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ozark Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Joplin, Mo.</u>
24. FUNERAL DIRECTOR <u>Johnston-Simpson, Webb City, Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>12-27-63</u>	
		26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switzer</u>	

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 Jack C. Simpson
Licensed Embalmer No. 4647
P. O. Address Webb City, 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.