

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-048668

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 185

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 24 1963		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Macon		b. CITY (If outside corporate limits, give TOWNSHIP only) Macon		a. STATE Missouri b. COUNTY Macon	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Samaritan Hospital		Length of stay in 1b Macon		c. CITY OR TOWN Macon	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 802 Jackson St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX	
First Middle Last LUCILLE CASE BAMMAN		Month Day Year Dec. 1 1963		Female	
6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/20/1911	
9. AGE (last birthday) 52		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and state or country) Yale, Michigan		12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Prentiss Case	
13b. MOTHER'S MAIDEN NAME Winifred Powers		14. NAME OF HUSBAND OR WIFE John F. Bamman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)	
17. INFORMANT John F. Bamman		Address Macon, Missouri		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) Terminal Uremia		DUE TO (b) systemic virus infection complicating long standing illness		DUE TO (c) chronic pyelonephritis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypothyroidism, Hypertension, Arteriosclerosis, Cerebral Encephalopathy		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 8:05 P.M. Death occurred at 8:05 P.M.		I attended the deceased from Frequent intervals, past 10 years and last saw her him alive on Dec. 1, 1963		m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) James E. Campbell, M.D.		22b. ADDRESS 1101 North Jackson Macon, Missouri		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/4/1963		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Gdns.	
23d. LOCATION (City, town, or county) (State) Macon Missouri		24. FUNERAL DIRECTOR Bram Funeral Home		25. DATE RECD. BY LOCAL REG. 12/13/63	
26. REGISTRAR'S SIGNATURE Kath M. Neely					

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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

DEC 30 1963

FILED DEC 24 1963

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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 P. Lester Beam

Licensed Embalmer No. _____

P. O. Address _____

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.