

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049428

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12684 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 6 1964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution: residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year		5. SEX	
6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (last birthday) Months Days Hours Min.	
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME	
13. MOTHER'S M maiden name		14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)		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		INTERVAL BETWEEN ONSET AND DEATH	
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.		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		Dec. 11, 1963, to Dec. 21, 1963		and last saw her alive on 12-21-63	
Death occurred at		1:10 P.M.		on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county)		23e. DATE RECD. BY LOCAL REG.		23f. REGISTER'S SIGNATURE	

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

VS 300
Rev. 4/59

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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

Lester A. Vitt

Licensed Embalmer No. 3254

P. O. Address

Washington, 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.