

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0035102

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 232

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 2 1967					
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Henry</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u> Length of stay in 1b <u>1 mo.</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo</u> b. COUNTY <u>Henry</u></p> <p>c. CITY OR TOWN <u>Clinton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>607 N. 4th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED First Middle Last <u>EMMA Rene Marksberry</u></p> <p>4. DATE OF DEATH Month Day Year <u>9 - 27 - 1967</u></p>					
<p>5. SEX <u>F</u></p>	<p>6. COLOR OR RACE <u>W</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>12-25-09</u></p>	<p>9. AGE (last birthday) <u>57</u></p>	<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>St. Clair County</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>USA</u></p>	
<p>13a. FATHER'S NAME <u>John Stoneking</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Charlotta Phelps</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Chester Marksberry</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>490-44-6798</u></p>		<p>17. INFORMANT <u>Chester Marksberry, Clinton Mo</u> Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Myocarditis</u></p> <p style="text-align: right;">INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p style="text-align: right;">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</p>					
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>					
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>Nov. 1965</u> to <u>9-27-67</u> and last saw <u>him</u> alive on <u>9-27-67</u> Death occurred at <u>4:45</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>					
<p>22a. SIGNATURE (Degree or title) <u>Hugh B. Walker, MD</u></p>				<p>22b. ADDRESS <u>Clinton, Mo</u></p>	
<p>22c. DATE SIGNED <u>9-27-67</u></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>9-29-67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Urich</u></p>	
<p>23d. LOCATION (City, town, or county) (State) <u>Urich, Mo.</u></p>					
<p>24. FUNERAL DIRECTOR <u>Snover's Funeral Home, Urich, Mo.</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>Sept. 27, 1967</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u></p>

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 15 1967

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 Merle H Snow

Licensed Embalmer No. 4034

P. O. Address Urich, 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.