MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050646 STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 6269 ~~4145~~ Registrar's No. 1

FILED JAN 6 1964

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

Item	Value
1	1120
2	1120
3	
4	0
5	1
6	
7	0
8	2
9	4201
10	
11	
12	90-0
13	30

DATE AMENDED — AMENDMENTS ON THIS RECORD ARE AS FOLLOWS — INSTEAD OF — DOCUMENT — SHOULD READ — ITEM NO. — BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
   a. COUNTY: Webster
   b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Ozark Township — Length of stay in 1b: 30 years
   c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Marshfield R 1 — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Missouri — b. COUNTY: Webster
   c. CITY OR TOWN: Marshfield — Inside Limits: Yes ☐ No ☐
   d. STREET ADDRESS (If outside, give location): Marshfield — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: William — Last: Losey

4. DATE OF DEATH: Month: Dec — Day: 29, — Year: 63

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12/16/1890
9. AGE (last birthday): 73 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): St John, Mo.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: J.S.Losey
13b. MOTHER'S MAIDEN NAME: Sarah Howser
14. NAME OF HUSBAND OR WIFE: Eulalia Losey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 1912-1915
16. SOCIAL SECURITY NO.: 486-24-2382
17. INFORMANT — Address: Mrs.Eulalia Losey, Marshfield

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Coronary Occlusion, Acute — Few minutes

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis, Genl & Coronary. — 9 years

DUE TO (c): Hypertension, Vascular. — 9 years

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1954, to Dec. 27, 1963 and last saw him alive on Dec. 27, 1963
Death occurred at 5:30 P.M. P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C.R. MacDonnell, M.D.
22b. ADDRESS: Marshfield, Mo.
22c. DATE SIGNED: 12/31/63

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1/2/64
23c. NAME OF CEMETERY OR CREMATORY: Green Lawn
23d. LOCATION (City, town, or county) (State): Springfield, Mo

24. FUNERAL DIRECTOR — ADDRESS: Smith Funeral Home, Mt Vernon, Mo.
25. DATE RECD. BY LOCAL REG.: 12/31-63
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

JAN 7 1964

JAN 28 1964

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 [signature]

Licensed Embalmer No. 5159

P. O. Address Springfield 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.