

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0039102

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 1296

VS 300
Rev. 4/59
10055
20050
3
4 1
5 2
6
7 1
8 0
9 157x
10
11
12 2-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH COUNTY <u>BARRETT</u> CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MONETT</u> Length of stay in 1b <u>4 WKS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BARRY</u> c. CITY OR TOWN <u>EXETER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. VINCENTS HOSP.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NONE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIS ANN GURLEY</u>			4. DATE OF DEATH Month Day Year <u>OCTOBER 27, 1964</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>11-27-1887</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 <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>CHERRYVALE, KANS.</u>
13a. FATHER'S NAME <u>MARY MILLER</u>		13b. MOTHER'S MAIDEN NAME <u>JANE ROBERTS</u>	14. NAME OF HUSBAND OR WIFE <u>MONROE GURLEY (DEC)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>NORMA SMITH, EXETER, MO.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myast operation (Exploratory)</u> DUE TO (b) <u>Carcinoma - head pancreas</u> DUE TO (c) <u>Chronic Debl bladder disease & str</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u> <u>Yrs</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 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 <u>1-10-64</u> to <u>10-27-64</u> and last saw her/him alive on <u>10-27-64</u> Death occurred at <u>9 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank R. Ben MD</u>		22b. ADDRESS <u>Monett Mo</u>	22c. DATE SIGNED <u>10-31-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-30-1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>EXETER, MO.</u>
24. FUNERAL DIRECTOR <u>DOYLE E. WILLIAMSON, CASSVILLE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-31-64</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. J. N. Cook</u>

USE BLACK INK OR OR TYPewriter RIBBON

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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 Boyle E Williams

Licensed Embalmer No. 4883

P. O. Address Cassville, 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.