

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-042705  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 11 Primary Registration District No. 4024 Registrar's No. 85

FILED DEC 3 1965

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BARRY</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO.</b> b. COUNTY <b>BARRY</b>                         |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>CASSVILLE</b>  |   | Length of stay in 1b<br><b>12 hrs.</b>  | c. CITY OR TOWN <b>CASSVILLE</b><br>Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>SO. BARRY CO. HOSPITAL</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>2 Mi. N. Of Cassville</b><br>Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>          |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARTHA</b> Middle <b>ELIZABETH</b> Last <b>REED</b>  |   |   | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>22</b> Year <b>1965</b>  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/5/66</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homekeeper</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 9. AGE (last birthday)<br><b>99</b><br>IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____  |
| 13a. FATHER'S NAME<br><b>John A. Bayless</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Rebecka Chaney</b>  | 14. NAME OF HUSBAND OR WIFE<br><b>S.A. Reed, Dec'd.</b>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>none</b>  | 17. INFORMANT<br><b>Virginia Reed, Cassville, Mo.</b><br>Address _____  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastro Intestinal Hemorrhage</b>  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Bowel Obstruction - Fecal Impaction</b>  |   |   | <b>5 days</b>   |
| DUE TO (c) <b>Senility</b>   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Hypostatic Viroi Pneumonia</b>   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <b>Nov. 22, 1965</b> to <b>Nov. 22, 1965</b> and last saw <sup>her</sup> him alive on <b>Nov. 22, 1965</b><br>Death occurred at <b>8:00 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE<br><i>Thomas J. Durn</i>  |   | (Degree or title) _____   | 22b. ADDRESS<br><b>187 Gravel St., Cassville, Mo.</b>   |
|  |   |   | 22c. DATE SIGNED<br><b>11/23/65</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>11/24/65</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Cassville, Mo. 65</b>   |
| 24. FUNERAL DIRECTOR<br><b>D. Williamson, Cassville, Mo.</b>   |   | ADDRESS _____   | 25. DATE RECD. BY LOCAL REG. <b>11-26-65</b> 26. REGISTRAR'S SIGNATURE<br><i>Grace Williams</i>   |

**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 Royle E. Wellenman

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.

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Burial permit obtained Nov 23-65 S.W.