

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025963

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 206 Primary Registration District No. 5757 Registrar's No. 40

FILED JUL 19 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>MADISON</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. MICHAEL</u>	a. STATE <u>MISSOURI</u>	b. COUNTY <u>MADISON</u>
Length of stay in 1b <u>1 YR.</u>		c. CITY OR TOWN <u>FREDERICKTOWN</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D. # 1</u>		d. STREET ADDRESS <u>R.F.D. # 1</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>CHARA</u>	Middle <u>SARAH</u>	Last <u>DUDLEY</u>	Month <u>JULY</u>	Day <u>11</u>	Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</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>3-29-1880</u>	9. AGE (last birthday) <u>81</u>	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) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>ST. GENEVIEVE Co. MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN M'CLANAHAN</u>	13b. MOTHER'S MAIDEN NAME <u>KATHERINE CLAY</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>N</u>	16. SOCIAL SECURITY NO. <u>N/A</u>	17. INFORMANT <u>IRENE HAMBLEN</u>	Address <u>FREDERICKTOWN</u>
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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) <u>marked mitral insufficiency</u>	<u>also Arterio Sclerous</u>	<u>4 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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
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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.)
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20c. TIME OF INJURY Hour s.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased 10 years to 7-13-61 and last saw her alive on Can not say  
Death occurred at 6:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>S. C. Slaughter M.D.</u>	22b. ADDRESS <u>135 W. Main Fredericktown</u>	22c. DATE SIGNED <u>7-13-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-13-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC</u>	23d. LOCATION (City, town, or county) (State) <u>FARMINGTON Mo.</u>
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24. FUNERAL DIRECTOR <u>ADAMSON-WEBB</u>	ADDRESS <u>FREDERICKTOWN Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-15-1961</u>	26. REGISTRAR'S SIGNATURE <u>Florence Tucker</u>
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DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 ITEM NO.  
 BY AFFIDAVIT OF

**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 Raymond K. Wilson

Licensed Embalmer No. 4884

P. O. Address Fredenshten

**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.