

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0020317

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

MY FILED 19 64

Registration District No. 316 Primary Registration District No. 6074 Registrar's No. 177

VS 300 Rev. 4/59	DATE AMENDED
1 <u>OT</u>	
2 <u>1964</u>	
3	
4 <u>1</u>	
5 <u>2</u>	
6	
7 <u>1</u>	
8 <u>2</u>	
9 <u>334x</u>	
10	
11	
12 <u>862</u>	
13 <u>1-0</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. FRANCOIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELWITS RPT 1 TRAP</u>		c. CITY OR TOWN <u>CANTWELL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROSECRETS NURS. HOME</u>			d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>E.</u> Last <u>HAILE</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>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>12-22-1875</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House-wife</u>		11. BIRTHPLACE (City and state or country) <u>ST. FRANCOIS, CO. MO</u>	
13a. FATHER'S NAME <u>JAMES FORSHEE</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>I.L. HAILE</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>Bessie Calvert Cantwell, 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>Labor Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral circulatory insufficiency</u>					<u>month</u>
DUE TO (c) <u>Arteriosclerosis</u>					<u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>advanced senility</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)			
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>Jan 21 - 1964</u> to <u>May 7 - 1964</u> and last saw her alive on <u>May 7, 1964</u> Death occurred at <u>11:45 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>FD Thompson</u>			22b. ADDRESS <u>Flat River, Mo</u>		22c. DATE SIGNED <u>3/11/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>		<u>5-11-64</u>	<u>HEROD CEM.</u>		<u>NEAR CANTWELL, MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>CALDWELL AND SONS FLAT RIVER, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>May 11, 1964</u>		26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>	

USE BLACK INK OR TYPEWRITER RIBBON

MAY 21 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 Donald Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River, MD

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.