

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 336 Primary Registration District No. 6131 Registrar's No. 20038895

FILED OCT 2 1964

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DOCUMENT
1 1010			
2 1010			
3			
4 0			
5 0			
6			
7 1			
8 2			
9 1201			
10			
11			
12 90-3			
13 1-0			
USE BLACK INK OR TYPEWRITER RIBBON	SHOULD READ	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Montier</u> Length of stay in 1b		c. CITY OR TOWN <u>Montier</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>Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>V.</u> Last <u>Rymers</u>			4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1964</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rancher</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>84</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Lacarne, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>M. J. Rymers</u>		13b. MOTHER'S MAIDEN NAME <u>Emily K. Reynolds</u>	
14. NAME OF HUSBAND OR WIFE		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>Yes</u>		17. INFORMANT <u>Marian Rymers Rt. 3 BirchTree, Mo.</u> Address	
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>NATURAL CAUSES</u> DUE TO (b) <u>CORONARY THROMBOSIS (PROBABLY)</u> DUE TO (c) <u>Frank W Jones Coroner of Shannon Co.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>(Notified)</u>			INTERVAL BETWEEN ONSET AND DEATH
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 <u>9</u> Month <u>19</u> Day <u>1964</u> a.m. p.m.	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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank W Jones Coroner</u>		22b. ADDRESS <u>Emmence MO.</u>	
22c. DATE SIGNED <u>9-26-1964</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/20/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montier Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Montier, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-1-64</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Rollins per Ann Selvey</u>

320000

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Barnes' Permit obtained

STATEMENT BY LICENSED EMBALMER

E-01

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 Charles D. Partain

Licensed Embalmer No. 5107

P. O. Address Mt. View, 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.