

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0017305

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 336 Primary Registration District No. 6131 Registrar's No. 342

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 17 1967

1. PLACE OF DEATH a. COUNTY <u>Shannon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Teresita MONTIER Twp.</u> Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hatton Rest Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u> c. CITY OR TOWN <u>Mtn. View, Mo.</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>Lottie</u> Middle <u>S.</u> Last <u>Holden</u>	4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1967</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>4/12/1888</u>	9. AGE (last birthday) <u>78</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	11. BIRTHPLACE (City and state or country) <u>Hutton Valley, Mo.</u>	12. CITIZEN OF WHAT COUNTRY
--	-----------------------------------	--	-----------------------------

13a. FATHER'S NAME <u>Jim Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</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>None</u>	17. INFORMANT Address <u>Jessie Holden Mtn. View, 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>Cerebral thrombosis</u> DUE TO (b) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriol neuphro sclerosis, severe</u>	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 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 1960 to 1967 and last saw her/him alive on 4/4/67
 Death occurred at 4/8/67 6 p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M.C. Walton M.D.</u>	22b. ADDRESS <u>Mtn. View, Mo.</u>	22c. DATE SIGNED <u>4/11/67</u>
--	------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/11/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Center Hill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Mountain View, Missouri</u>
---	----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Apr 14 1967</u>	26. REGISTRAR'S SIGNATURE <u>Mike Rollins</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59

1 1010

2 1010

3

4 1

5 2

6

7 0

8 0

332X

10

11

12 26-0

13 1-0

APR 27 1967

Funeral Home located Prior to time of burial

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 Carl D. Bell

Licensed Embalmer No. 5368

P. O. Address W. W. Ward, 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.