

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-021219
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 213

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0942
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4 0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Flat River		Length of stay in 1b	c. CITY OR TOWN Flat River
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 102 Stone St.		Inside Limits. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 102 Stone St.
3. NAME OF DECEASED (Type or print) First JAMES Middle C. Last LAIRD		4. DATE OF DEATH Month May Day 29 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/7/1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 82
11. BIRTHPLACE (City and state or country) Bollinger Co. Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John W. Laird		13b. MOTHER'S MAIDEN NAME Martha Ann Keen	14. NAME OF HUSBAND OR WIFE #7
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Laird Jackson, Mo.		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) Acute Bronchial occlusion DUE TO (b) Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) old age -			INTERVAL BETWEEN ONSET AND DEATH 10 to 15 Min 4 hrs
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"/>	
20c. TIME OF INJURY Hour a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 May 29 1963 to May 29 1963 and last saw him alive on May 29 1963 Death occurred at 8:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F W Zupan MD		22b. ADDRESS Flat River Mo	22c. DATE SIGNED (Style) 5/31/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/1/1963	23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery	23d. LOCATION (City, town, or county) Farmington, Mo.
24. FUNERAL DIRECTOR Murphy L. Sparks Flat River, Mo.		25. DATE RECD. BY LOCAL REG. May 31, 1963	26. REGISTRAR'S SIGNATURE Esther Rudloff

JUN 26 1963

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 Walter L. Sparks

Licensed Embalmer No. 4339

P. O. Address 1401 River Rd

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.