

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0002169

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. SSN Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 4 1965

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1 0500				
2 0941				
3				
4 0				
5 0				
6				
7 0				
8 2				
9 X				
10				
11 050				
12 92-3				
13 1-0				
	SHOULD READ			
	ITEM NO.			BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jefferson</u>		a. STATE <u>MO</u>	b. COUNTY <u>ST FRANCOIS</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Festus</u>		Length of stay in 1b <u>D. O. A.</u>	c. CITY OR TOWN <u>BONNE TERRE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jeff. Memorial Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>46 N. ALLEN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>James A.</u> Middle <u>McDaniel</u> Last <u>Jr.</u>		Month <u>1-</u> Day <u>22-</u> Year <u>65</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>1-14-41</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRONIC INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIR CRAFT</u>	9. AGE (last birthday) <u>24</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>BONNE TERRE, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>JAMES A. Mc DANIEL</u>		13b. MOTHER'S MAIDEN NAME <u>HELEN BUSCHER</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>YES 1959-1963</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>JAUSTIN Mc DANIEL, 46 N. ALLEN ST</u> Address <u>BONNE TERRE, MO.</u>	
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>multiple skull fractures.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) _____			
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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Auto - Truck Accident.</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>1-22-65</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. CITY, TOWN, OR LOCATION <u>PLATTAN TOWNSHIP</u>	COUNTY <u>Jeff.</u> STATE <u>MO.</u>
21. I attended the deceased from <u>Coroner's View</u> and last saw her alive on _____ Death occurred at <u>2:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James C. Palmer D.C. Coroner</u>		22b. ADDRESS <u>Heater Mo.</u>	
22c. DATE SIGNED <u>1-22-65</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 24, 1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST FRANCOIS MEM. PK.</u>	23d. LOCATION (City, town, or county) (State) <u>BONNE TERRE MO</u>
24. FUNERAL DIRECTOR <u>C. Z. Boyer & Son</u>		25. DATE RECD. BY LOCAL REG. <u>1-26-65</u>	26. REGISTRAR'S SIGNATURE <u>James B. Boyer</u>

MAR 2 1985
MAR 2 1985

FEB 8 1985

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 Berlin T. Boyers Jr

Licensed Embalmer No. 5117

P. O. Address Bone Tery, 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.