

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

UNFILED 24824
 Registration District No. 3046 Primary Registration District No. 40023895 REGISTRAR'S NO. 40023895 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
 Rev. 4/59

1 0681
 2 0681
 3
 4 0
 5 2
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 7 0
 8 0
 9 1538
 10
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 12 90-2
 13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Moniteau</u>				2. USUAL RESIDENCE (Where deceased lived, or if in institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Moniteau</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>California, Mo</u>			Length of stay in 1b <u>20 Yrs</u>		c. CITY OR TOWN <u>California, Mo</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>Home-605 N Owns</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>605 N Owns</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Stephie</u> Middle <u>Addison</u> Last <u>Albin</u>			4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1964</u>				
5. SEX <u>Male</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>3/1/84</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Homes</u>		11. BIRTHPLACE (City and state or country) <u>Cooper Co</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Benjamin F. Albin</u>			13b. MOTHER'S MAIDEN NAME <u>Arrbella Hurt</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>488-24-6669</u>		17. INFORMANT Address <u>Mrs Ernest Flippin-California, 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 <u>5 days</u>
IMMEDIATE CAUSE (a) <u>Cachexia</u>							
DUE TO (b) <u>Carcinomatosis</u>							
DUE TO (c) <u>Primary Carcinoma of Colon</u>							
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 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> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>						
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> </u> to <u> </u> and last saw her/him alive on <u> </u> . Death occurred at <u>12/15A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>W.H. Moore DO</u> (Degree or title)			22b. ADDRESS <u>California, Mo</u>			22c. DATE SIGNED <u>6-20-64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/21/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clarksburg, Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Bowlin Funeral Home-California, Mo</u>			ADDRESS <u>6-22-1964</u>		25. DATE RECD. BY LOCAL REG. <u>6-22-1964</u>		
26. REGISTRAR'S SIGNATURE <u>Helen Papejay</u>							

USE BLACK INK OR TYPEWRITER RIBBON

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 Jack H. Bowler

Licensed Embalmer No. 4933

P. O. Address California, 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.