

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0030627

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 417

FILED 08 64

VS 300
Rev. 4/59

1 0168

2 0168

3 2

4 1

5 1

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9 190x

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11

12 270

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>CAPE GIRARDEAU</u>		a. STATE <u>MO</u> b. COUNTY <u>CAPE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>		c. CITY OR TOWN <u>CAPE GIRARDEAU</u>	
Length of stay in lb <u>7 YEARS</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>ST. FRANCIS - HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>#1 So. PACIFIC</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED			4. DATE OF DEATH
First Middle Last <u>MAXINE HESTER</u>			Month Day Year <u>AUG. 25 1964</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3 1919</u>
9. AGE (last birthday) <u>35</u>		10. KIND OF BUSINESS OR INDUSTRY <u>HOUSE</u>	11. BIRTHPLACE (City and state or country) <u>LUTESVILLE, MO</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>DAN MOUSER</u>		14. NAME OF HUSBAND OR WIFE <u>RALPH HESTER</u>	
13b. MOTHER'S MAIDEN NAME <u>NOLA EAKER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Miss Mildred Mouser</u> Address <u>St. Louis, MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>has ac. pneumonia</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 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 <u>8-22-64</u> to <u>8-25-64</u> and last saw <u>him</u> alive on <u>8-25-64</u>			
Death occurred at <u>4:15</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dick Blaudens, M.D.</u>		22b. ADDRESS <u>CAPE GIRARDEAU, MO</u>	22c. DATE SIGNED <u>9-1-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-28-64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOLLINGER COUNTY MEM.</u>	23d. LOCATION (City, town, or county) (State) <u>LUTESVILLE, MO</u>
24. FUNERAL DIRECTOR <u>Gene Ward, Lutesville, MO</u>		25. DATE RECD. BY LOCAL REG. <u>9-2-64</u>	26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>

USE BLACK INK OR TYPEWRITER RIBBON

SEP 11 1964

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 Neil H. Grosshede

Licensed Embalmer No. 4994

P. O. Address Cape Girardeau 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.