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STATE OF MISSOURI }
CITY OF JEFFERSON } ss

I HEREBY CERTIFY that this is an exact reproduction of the certificate for the person named therein as it now appears in the permanent records of the Bureau of Vital Records of the Missouri Department of Health and Senior Services. Witness my hand as State Registrar of Vital Records and the Seal of the Missouri Department of Health and Senior Services this date of

MAR 26 2020

Kenneth J. Palermo

MO 580-1241 (2-2020)

State Registrar

VS-804B

FILED

DEC 29 1980

DEPARTMENT OF SOCIAL SERVICES - MISSOURI DIVISION OF HEALTH
(PHYSICIAN, MEDICAL EXAMINER OR CORONER)
CERTIFICATE OF DEATH

STATE FILE NUMBER
124 80 025553

REGISTRATION DISTRICT NO. 1

PRIMARY REGISTRAR: DISTRICT NO. 300

REGISTRAR'S NO. 375

1. DECEDENT-NAME FIRST MIDDLE LAST Mary Josephine Vardiman		SEX 2. Female	DATE OF DEATH (Mo., Day, Yr.) 3. Dec. 16, 1980						
4. RACE - (e.g., White, Black, American Indian, etc.) (Specify) White		5a. AGE - Last Birthday (Yrs.) 95	5b. UNDER 1 YEAR MOS. DAYS	5c. UNDER 1 DAY HOURS MINS.	6. DATE OF BIRTH (Mo., Day, Yr.) Jan. 31, 1885	7a. COUNTY OF DEATH Adair			
7b. City, Town or Location of Death Kirksville		7c. Hospital or Other Institution - Name (If not in either, give street and number) Kirksville Osteopathic Hospital							
8. STATE OF BIRTH (If not in U.S.A., name country) Missouri		9. CITIZEN OF WHAT COUNTRY USA		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) -----	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
13. SOCIAL SECURITY NUMBER 489-36-4617		14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			14b. KIND OF BUSINESS OR INDUSTRY -----				
15a. RESIDENCE-STATE Missouri		15b. COUNTY Adair		15c. CITY, TOWN OR LOCATION AND ZIP CODE Kirkville 63501		15d. STREET AND NUMBER 316 S. Osteopathy		15e. INSIDE CITY LIMITS (Specify Yes or No) Yes	
16. FATHER-NAME FIRST MIDDLE LAST Phillip W. Harris		17. MOTHER-MAIDEN NAME FIRST MIDDLE LAST Almedia Holmes							
18a. INFORMANT-NAME (Type or Print) Ross Vardiman		18b. MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP 1111 E. Patterson, Kirkville, Missouri 63501							
19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) DATE December 18, 1980		19b. CEMETERY OR CREMATORY-NAME Ridge Park Cemetery		19c. LOCATION CITY OR TOWN STATE Marshall, Missouri					
20a. FUNERAL SERVICE LICENSEE OF Person Acting As Such (Signature) Doris W. Ratliff		20b. NAME OF FACILITY Campbell Lewis Funeral		20c. ADDRESS OF FACILITY Home, Marshall, MO					
21a. REGISTRAR (Signature) Doris W. Ratliff		21b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) Dec 23 1980							
22a. To the best of my knowledge, death occurred at the time, date and place as due to the cause(s) stated. (Signature and Title) Doris W. Ratliff		22b. DATE SIGNED (Mo., Day, Yr.) 12/19/80		22c. HOUR OF DEATH 1:12		22d. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) R. G. RYTE, DO Kirkville, Mo		22e. MO. LICENSE NO. 33551	22f. IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify) IN OT
23a. To be Completed by CERTIFYING PHYSICIAN ONLY DATE SIGNED (Mo., Day, Yr.)		23b. To be Completed by MEDICAL EXAMINER OR CORONER ONLY DATE SIGNED (Mo., Day, Yr.)		23c. HOUR OF DEATH		23d. PRONOUNCED DEAD (Mo., Day, Yr.)		23e. PRONOUNCED DEAD (Hour)	
23d. QN		23e. AT		23f. M		23g. M		23h. M	
24. IMMEDIATE CAUSE PART I (a) Metabolic Failure (b) Cardiac arrest or Collapse (c) Congestive Heart Failure		25. ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c). Interval between onset and death 6 mi 30 mi 3 days							
26. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a) PART II Heart Failure of unknown Cause. Also of unknown Cause.		27. AUTOPSY (Specify Yes or No) No		28. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No) No					
29a. ACC. SUICIDE, HOM., UNDET., OR PENDING INVEST (Specify) No		29b. DATE OF INJURY (Mo., Day, Yr.)		29c. HOUR OF INJURY		29d. DESCRIBE HOW INJURY OCCURRED			
29e. INJURY AT WORK (Specify Yes or No)		29f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		29g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, COUNTY, STATE)		29h. IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK			

VS 300
Rev. 1/78

DECEDENT

IF DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

PARENTS

DISPOSITION

CERTIFIER

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE OF DEATH