

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1957

16158  
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 183

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Dr. Rodas

1. PLACE OF DEATH a. COUNTY <b>BOONE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CALLAWAY</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>COLUMBIA</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>TEBBETS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ELLIS FISCHER</b>			Length of stay in lb <b>35 DAYS</b>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>BROOKS</b> Last <b>COUNTS</b>				4. DATE OF DEATH Month <b>5</b> - Day <b>22</b> - Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-2-1889</b>		9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>REYNOLDS Co. MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JACKSON ANDREW COUNTS</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH JANE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Post Operative Cystectomy</b>				7 da.	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>Diabetes Mellitus</b>							
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. _____							
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 <b>4-17-57</b> to <b>5-22-57</b> and last saw <sup>her</sup> him alive on <b>5-22-57</b> Death occurred at <b>8:15 A m</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Red A. Rodas M.D.</b>				22b. ADDRESS <b>Ellis Fischer State Cancer Hosp</b>		22c. DATE SIGNED <b>5-22-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5/24/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Makane Cemetery, Makane, Mo.</b>		23d. LOCATION (City, town, or county) (State) <b>Makane, Mo.</b>		
24. FUNERAL DIRECTOR <b>Glen Manspin, Fulton, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>May 22, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. R. E. Palmer</b>	

JUN 11 1957

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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 *J. J. Ross*.....

Licensed Embalmer No. *255*

P. O. Address *Fuller*

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.