

pt. Health,  
r. & Welfare  
S. Public  
alth Service

V. S. 300  
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39185

STATE FILE NUMBER

FILED NOV 18 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 423

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Polk</u>	
b. CITY OR TOWN <u>Columbia</u> <small>(If outside corporate limits, give TOWNSHIP only)</small>		c. CITY OR TOWN <u>Humansville</u> <small>(If outside, give location)</small>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. Medical Center</u>		d. STREET ADDRESS <u>1 Mo.</u>	

3. NAME OF DECEASED (Type or print) <u>Charlotte</u> <u>Lee</u> <u>Pangborn</u>		4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>57</u>	
--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>April 10, 1896</u>	9. AGE (In years last birthday) <u>61</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 24 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	--	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Humansville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	--	--

13a. FATHER'S NAME <u>Frank Poppewell</u>	13b. MOTHER'S MAIDEN NAME <u>Irreta Weir</u>	14. NAME OF HUSBAND OR WIFE <u>Le Roy Pangborn</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT Address <u>Hospital Records</u>
--	----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <span style="float:right">INTERVAL BETWEEN ONSET AND DEATH - 2 hours</span>	
DUE TO (b) <u>Retroperitoneal hemorrhage, suspected</u> <span style="float:right">- 7 days</span>	
DUE TO (c) <u>Aplastic anemia</u> <span style="float:right">2924 - 4 months</span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thrombocytopenia purpura; pyelonephritis; agranulocytic anemia</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____ Month _____ Day _____ Year _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, shop, etc.) _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
--	---	--	---

21. I attended the deceased from <u>10/16/57</u> to <u>11/14/57</u> and last saw her alive on <u>11/14/57</u> Death occurred at <u>8:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>Frank H. Mohr, M.D.</u>	22b. ADDRESS <u>U. of Mo. Med Center, Columbia, Mo.</u>	22c. DATE SIGNED <u>11/14/57</u>
---	---	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/15/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Humansville, Mo.</u>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Lynn...</u> ADDRESS <u>Columbia</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 15 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

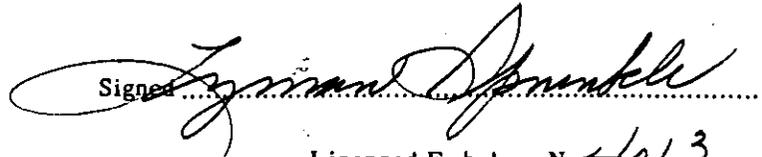
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4013  
P. O. Address Columbia, 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.