

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008825
STATE FILE NUMBER

FILED MAR 31 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 137

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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>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Ashland</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. of Mo. Med. Center</u>		Length of stay in 1b <u>39 das.</u>	d. STREET ADDRESS (If outside, give location) <u>RFD # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Pendleton Radabaugh</u>			4. DATE OF DEATH Month Day Year <u>3 22 58</u>			
5. SEX <u>Male</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>4-26-94</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Spencer, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Ira Radabaugh</u>		13b. MOTHER'S MAIDEN NAME <u>Mathe Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Frankie Radabaugh</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes give year or date of service) <u>yes July-Dec 1918</u>		16. SOCIAL SECURITY NO. <u>301-78-7018</u>	17. INFORMANT Address <u>Hospital Chart Stadium Rd. Columbia</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>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Gastrointestinal hemorrhage</u>		<u>4 days</u>
	DUE TO (c) <u>Idiopathic Thrombocytopenic Purpura</u>		<u>3 months</u>
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"/>

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.) <u>1</u>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 2-13-58 to 3-22-58 and last saw ^{her} him alive on 3-22-58
Death occurred at 12:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Diane Burkardt, M.D.</u>	22b. ADDRESS <u>U. of Mo. Medical Center</u>	22c. DATE SIGNED <u>3-22-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 24 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Man Salam Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ashland Mo.</u>
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24. FUNERAL DIRECTOR <u>Wm C. Burnett</u>	ADDRESS <u>Ashland Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Mar 24 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mar R E Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. MUST use only standard nomenclature in death certificate. No symptoms or signs to be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

APR 9 1958

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 *W^m L. Burnett*

Licensed Embalmer No. *3564*
P. O. Address *Ashland, 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.