

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017316
STATE FILE NUMBER

FILED MAY 19 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 220

300
1-57

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>Morgan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>BARNETT 0710</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>University Med Center</u>		Length of stay in lb <u>48 days</u>	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 <u>Shirley</u> Middle <u>Edward</u> Last <u>ROUTON</u>			4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-82</u>	9. AGE (In years last birthday) <u>75</u>	FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING Industry</u>		11. BIRTHPLACE (City and state or country) <u>Morgan Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>William Isaac Routon</u>		13b. MOTHER'S MAIDEN NAME <u>MARY JANE WILLIAMS</u>	
14. NAME OF HUSBAND OR WIFE		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>-</u>	
17. INFORMANT <u>HOSPITAL CHART</u>		Address			
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>Cardiac insufficiency</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Recent myocardial infarction (?)</u>					<u>5 minutes</u>
DUE TO (c) <u>4201</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia; prostatic hypertrophy; low salt syndrome</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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 <u>p.m.</u>					
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 Death occurred at <u>4/10/58</u> to <u>5/12/58</u> and last saw <u>him</u> alive on <u>5/12/58</u> at <u>8:05 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Frank R. Mohr, M.D.</u> (Degree or title)		22b. ADDRESS <u>U. of Missouri Med Center; Columbia, Mo.</u>		22c. DATE SIGNED <u>5/12/58</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE <u>May 4, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Big Rock</u>	
23d. LOCATION (City, town, or county) <u>Darned Mo.</u>		23e. (State)			
24. FUNERAL DIRECTOR <u>Miss W. Phillips</u> ADDRESS <u>Edgar</u>		25. DATE REC'D. BY LOCAL REG. <u>May 12 1958</u>		26. REGISTRAR'S SIGNATURE <u>Miss R E Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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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 *Louis D. Phillips*

Licensed Embalmer No. *3663*

P. O. Address *the class*

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.