

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031754

STATE FILE NUMBER

FILED SEP 22 1958

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 409

S. 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>Ripley</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>Briar</u> 0 9 10 0		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>Univ. of Missouri</u>		Length of stay in 1b <u>5 da.</u>	d. STREET ADDRESS (If outside, give location) <u>Route # 7</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>James David UZZLE</u>			4. DATE OF DEATH Month Day Year <u>9-12-58</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 checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-69</u>	9. AGE (In years) <u>88</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>?, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Jimmie Uzzle</u>		13b. MOTHER'S MARDEN NAME <u>Unknown (? Oats)</u>		14. NAME OF HUSBAND OR WIFE <u>Virginia widowed - UZZLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Rosie Foster Briar Mo</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>Aspiration Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Bilateral Pneumonia</u>					<u>2 days</u>
DUE TO (c) <u>Advanced Arteriosclerotic Heart Disease</u>					<u>40+ years</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? 4200 1 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. 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 <u>9/7/58</u> to <u>9/12/58</u> and last saw ^{him} her alive on <u>9/12/58</u> Death occurred at <u>6:20 pm</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Earl J. Wipfler, Jr., M.D.</u>			22b. ADDRESS <u>4. of Missouri Medical Center</u>		22c. DATE SIGNED <u>9/13/58</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9/13/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pocahontas, Arkansas</u>		23d. LOCATION (City, town, or county) <u>Pocanhontas, Arkansas</u>
24. FUNERAL DIRECTOR <u>Lyman Sprinkle, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Sept. 13, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

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.

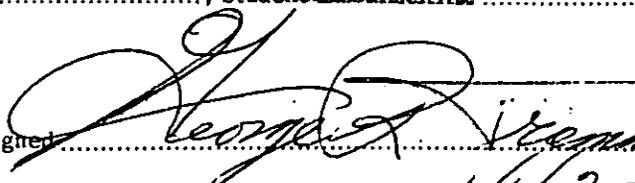
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STATEMENT BY LICENSED EMBALMER

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.~~

~~Worked under my personal supervision.~~

~~Signature of~~
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4425

P. O. Address Chamberlain

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.