

1. Health,
& Welfare
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036121

STATE FILE NUMBER

FILED OCT 20 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 964A

1. PLACE OF DEATH a. COUNTY <u>Breene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Breene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Willard</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp</u>		Length of stay in lb <u>3: hr 15 min</u>	d. STREET ADDRESS (If outside, give location) <u>0390</u>
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>GENE</u> Last <u>WHITE</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>7</u> Year <u>1958</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>Jan 18 - 1932</u>
9. AGE (In years last birthday) <u>26</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician - mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kraft Inc</u>	11. BIRTHPLACE (City and state or country) <u>Greenfield Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>HORACE WHITE</u>	
13b. MOTHER'S MAIDEN NAME <u>LUCILLE CATES</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel Mae white</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Korean War</u>		16. SOCIAL SECURITY NO. <u>486-34-6359</u>	17. INFORMANT 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>1-Crushing injury, right chest, with multiple rib fractures and massive hemopneumothorax.</u> <u>2-laceration, right lung.</u> DUE TO (b) <u>3-Exsanguinating hemorrhage, right chest.</u> <u>4-Possible rupture of left diaphragm.</u> DUE TO (c) <u>5-laceration of scalp.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</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 type="checkbox"/> NO <input checked="" 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.) <u>Automobile accident.</u>		20c. TIME OF INJURY Hour <u>8:15</u> Month <u>October</u> Day <u>7</u> Year <u>1958</u> a.m. <u>p.m.</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hi Way</u>	
20f. CITY, TOWN, OR LOCATION <u>Near Willard, Missouri</u>		20g. COUNTY <u>837</u> STATE	
21. I attended the deceased from <u>9:15 p.m., 10/7/58</u> to <u>11:15 p.m.,</u> and last saw <u>him</u> alive on <u>10/7/58</u> Death occurred at <u>11:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John W. Park, MD</u>		22b. ADDRESS <u>604 Medical Arts Bldg., Springfield 4, Missouri</u>	
22c. DATE SIGNED <u>10/8/58</u>		23a. BURIAL, CREMATION, REMOVAL (See 111)	
23b. DATE <u>10-10-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Walnut Grove - Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Breene - Samuel - Walnut Grove - Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-15-58</u>	
26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</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.

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 *Doyle L. Sauer*

Licensed Embalmer No. *4702*
P. O. Address *Asst. Gross*

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.