

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038863
STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 540

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Webster								
b. CITY (If outside corporate limits, give TOWNSHIP only) Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN EIKLAND 11200		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION M.U. Medical Center			Length of stay in 1b 6 day		d. STREET ADDRESS (If outside, give location) Rt. 2		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Russell T Caffey				4. DATE OF DEATH Month 12 Day 2 Year 58								
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-5-3		9. AGE (In years, months, days) 55		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PET MERCHANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME FRANK CAFFEY				13b. MOTHER'S MAIDEN NAME HARRIET DAY				14. NAME OF HUSBAND OR WIFE MAGGIE CAFFEY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 486-30-3571		17. INFORMANT Address M.U. Medical Center Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease, CONDITIONING FACTORS: Decompensated Diabetes Mellitus DUE TO (b) 1) Diabetes Mellitus DUE TO (c) 2) Generalized Arteriosclerosis 4200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition (a) 3) Pulmonary embolism 4) Thrombosis, PE, Popliteal artery & catheter										INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS		
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 form) of pt. foot									
20c. TIME OF INJURY Hour a.m. 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 bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE	
21. I attended the deceased from 26 NOV 58 to 2 DEC 58 and last saw him alive on 2 DEC 58 Death occurred at 2457 m on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE J. S. Sanders (Degree or title)				22b. ADDRESS MO University Med Center				22c. DATE SIGNED 2 DEC 58				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-2-1958		23c. NAME OF CEMETERY OR CREMATORY GRAHAM				23d. LOCATION (City, town, or county) (State) LACLEDE CO MO				
24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD				25. DATE RECD. BY LOCAL REG. Dec 5 1958		26. REGISTRAR'S SIGNATURE Mrs R E Palmer						

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.

MAY 15 1956

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 *Gene C. Hunt*

Licensed Embalmer No. *4731*

P. O. Address *Spfld, 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.

03-10-56