

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004439
STATE FILE NUMBER

FILED MAR 3 1959 Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY BATES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY CASS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BUTLER Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN HARRISONVILLE ¹⁹⁰ 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BUTLER Hospital		Length of stay in 1b 1 Day	d. STREET ADDRESS (If outside, give location) P.R. 3
3. NAME OF DECEASED (Type or print) First Middle Last James Douglas CLAUNCH			4. DATE OF DEATH Month Day Year Feb 27 1959
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-59
9. AGE (In years last birthday) 5		FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. 5 AM
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) BUTLER, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME James CLAUNCH	13b. MOTHER'S MAIDEN NAME BARBARA JEAN WEDDINGTON
14. NAME OF HUSBAND OR WIFE NONE		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. no
17. INFORMANT James CLAUNCH		Address HARRISONVILLE, Mo.	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE			INTERVAL BETWEEN ONSET AND DEATH 5 HRS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 12:15 P.M. to 2:00 P.M. and last saw him alive on 2-27-59 Death occurred at 4:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE Paul H. Green D.O. (Degree or title) 2		22b. ADDRESS HARRISONVILLE, Mo.	
22c. DATE SIGNED 2-28-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE MARCH 1-1959	
23c. NAME OF CEMETERY OR CREMATORY BUTLER Cemetery		23d. LOCATION (City, town, or county) (State) BUTLER, Missouri	
24. FUNERAL DIRECTOR Attinson Dickey Harrisonville, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 28. 1959	
26. REGISTRAR'S SIGNATURE Kendall Young			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Robert A. Kinross*

Licensed Embalmer No. *4902*

P. O. Address *Ferrisburgh*

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.