

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020387

STATE FILE NUMBER

FILED JUN 22 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 265

V. S. 300
Rev. 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>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Richmond</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Medical Center</u>		Length of stay in 1b <u>5 hrs. 46 min</u>	d. STREET ADDRESS (If outside, give location) <u>689/6</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Dooley</u> Last <u>Dooley</u>			4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1959</u>
9. AGE (In years last birthday) <u>5 hrs 46 min</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>46</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>46</u>
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) <u>Columbia, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME <u>Marjorie Dooley</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.
17. INFORMANT <u>Center Hospital Chart</u>		Address <u>University Medical</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>Respiratory Distress Syndrome</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Prematurity</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7735</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>1 day</u>
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 _____ a.m. _____ p.m. Month, Day, Year _____		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>6-16-59</u> to <u>6-16-59</u> and last saw ^{her} _{him} alive on <u>6-16-59</u> Death occurred at <u>5:55 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>(Grand) VanLeusen MD</u>		22b. ADDRESS <u>Univ. Hosp. - Columbia Mo.</u>	
22c. DATE SIGNED <u>6-16-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>June 17, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Univ. Medical Center</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u>
24. FUNERAL DIRECTOR <u>M. D. Crevelin</u>		ADDRESS <u>State Anatomical Board</u>	25. DATE RECD. BY LOCAL REG. <u>June 18, 1959</u>
26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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 ^{not} was embalmed, by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.....

P. O. Address.....

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.