

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-021927

FILED JUL 14 1959

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 105 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Wasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence Before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webb City</u>		Length of stay in 1b <u>8 hrs.</u>	c. CITY OR TOWN <u>Webb City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jane Chinn Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Jane Chinn Hosp</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Dedrickson Infant Daughter</u>			4. DATE OF DEATH Month Day Year <u>7-6-1959</u>			
5. SEX <u>Female</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>7-6-59</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Webb City Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Russell Dedrickson</u>		13b. MOTHER'S MAIDEN NAME <u>Arlene Audo</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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Russell Dedrickson - Carl Det No</u>	Address <u>Carl Det No</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Prematurity</u>	<u>6 1/2 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Miscarriage</u>	<u>8 hrs.</u>
	DUE TO (c) <u>ablated Placenta, Cause Unknown</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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 7-6-59 to 7-6-59 and last saw her live on 7-6-59
Death occurred at 8:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>DD</u>	22b. ADDRESS <u>6247 Broadway Webb City Mo</u>	22c. DATE SIGNED <u>7/7/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-8-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Carl Det Mo R.I.</u>
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24. FUNERAL DIRECTOR <u>Lon Roney - Carl Det No</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-8-59</u>	26. REGISTRAR'S SIGNATURE <u>Ms. Madeline Switzer</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Jack C. Simpson

Licensed Embalmer No. *464*

P. O. Address *Webb City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.