ealth,
Welfare
ublic
ervice

300
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-023970

STATE FILE NUMBER

FILED JUL 2 1959 Registration District No. 379 Primary Registration District No. 4563 Registrar's No. 15

1. PLACE OF DEATH
a. COUNTY WRIGHT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MANSFIELD — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MANSFIELD HOSP' — Length of stay in 1b 5 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY WEBSTER
c. CITY OR TOWN MARSHFIELD — Inside Limits Yes ☐ No ☑
STREET ADDRESS (If outside, give location) ROUTE 3 — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First BEN Middle JAMES Last UNDERWOOD
4. DATE OF DEATH Month 6 Day 5 Year 59
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 6-1-59
9. AGE (In years last birthday) — IF UNDER 1 YEAR Months Days 5 — IF UNDER 24 HRS Hours Min.
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) WRIGHT CO. MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME PAUL UNDERWOOD
13b. MOTHER'S MAIDEN NAME CLARA
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 PAUL UNDERWOOD Address MARSHFIELD MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Erythroblastosis fetalis — INTERVAL BETWEEN ONSET AND DEATH 4 days?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bronchial Pneumonia — 2 days
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7700
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6/2/59, to and last saw her (him) alive on 6/5/59
Death occurred at 12:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. R. Gill (Degree & title) D.O.
22b. ADDRESS Seymour
22c. DATE SIGNED 6/10/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 6-6-59
23c. NAME OF CEMETERY OR CREMATORY SEYMOUR Cemetery
23d. LOCATION (City, town, or county) (State) WEBSTER Co. MO.

24. FUNERAL DIRECTOR Robert Bergman ADDRESS Seymour, Mo.
25. DATE RECD. BY LOCAL REG. 6-23-59
26. REGISTRAR'S SIGNATURE [illegible]

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

6-22-59

STATEMENT BY LICENSED EMBALMER

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

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student ..... Signed Max L Miller

Signature of Student Embalmer

Licensed Embalmer No. 472

Not Embalmed

P. O. Address Mansfield

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.