RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 20 1959 38

59–024114
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 311

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Columbia
Length of stay in 1b: 2hrs 30 min.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: University Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Howard
c. CITY OR TOWN: Fayette
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 311 East Walnut
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Clearie Middle: Davis Last: Bruce
4. DATE OF DEATH: Month 7 Day 13 Year 1959
5. SEX: Female
6. COLOR OR RACE: Negroe
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-6-07
9. AGE (last birthday): 52
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HR: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Arkansas
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Rowland Bruce
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Record Address

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)	Cardiac Arrest (despite defibrillation)	30 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Aspiration of Vomitus	30 minutes
DUE TO (c)	Small bowel obstruction due to adhesions	24 hours

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. ☐ Yes ☐ No ☒ Unknown

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 7/13/59, to 7/13/59 and last saw her/him alive on 7/13/59
Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Earl J. Whipley Jr. (Degree or title) M.D.
22b. ADDRESS: U. of Mo. Medical Center
22c. DATE SIGNED: 7-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 17, 1959
23c. NAME OF CEMETERY OR CREMATORY: City Cemetery
23d. LOCATION (City, town, or county) (State): Fayette Mo.

24. FUNERAL DIRECTOR: Ralph H. Carr ADDRESS: Fayette Mo.
25. DATE RECD. BY LOCAL REG.: July 14, 1959
26. REGISTRAR'S SIGNATURE: Mrs R.E. Palmer

(Licensed Embalmer's Statement on Reverse Side)

JUL 28 1969

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 Donald L. Roberts

Licensed Embalmer No. 4723

P. O. Address Fayette, M

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