

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 20 1959 38

59-024120

Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 303

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY BOONEI				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Nodaway			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COLUMBIA MISSOURI			Length of stay in 1b		c. CITY OR TOWN OSCEOLA, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIVERSITY Med Center				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) % WAITE Rest Home	
3. NAME OF DECEASED (Type or print) First ALVIN Middle (None) Last CRIFE				4. DATE OF DEATH Month July Day 10 Year 1959			
5. SEX Male	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 4-5-71	9. AGE (last birthday) 86	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) None			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) St. Clair Mo		12. CITIZEN OF WHAT COUNTRY U. S.
13a. FATHER'S NAME Victor Crife			13b. MOTHER'S MAIDEN NAME SARAH ?			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)			16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonitis							INTERVAL BETWEEN ONSET AND DEATH minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Broncho pneumonia, bilateral							3 weeks
DUE TO (c) Intertubercular fracture, right femur							5 weeks
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	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) Patient fell in rest home			
20c. TIME OF INJURY Hour 9:00 a.m. _____ p.m. _____		Month, Day, Year 6-5-59					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Waite Rest Home		20f. CITY, TOWN, OR LOCATION Osceola,		COUNTY St. Clair	STATE Mo.
21. I attended the deceased from 6-8-59 to 7-10-59 and last saw her alive on 7-10-59 Death occurred at 5:12 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Earl J. Whipple, Jr., M.D.				22b. ADDRESS U. of Mo. Medical Center		22c. DATE SIGNED 7-10-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7/11/59		23c. NAME OF CEMETERY OR CREMATORY Osceola Missouri		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR Parker Funeral Home				ADDRESS Columbo- Missouri		25. DATE RECD. BY LOCAL REG. July 11 1959	
26. REGISTRAR'S SIGNATURE Mrs R E Palmer							

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 George Kerby

Licensed Embalmer No. 475

P. O. Address Columbus, Mo.

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