URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 1959

59–035162

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 529

ENDED

1. PLACE OF DEATH
a. COUNTY Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia
Length of stay in 1b: 3 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Boone
c. CITY OR TOWN Columbia
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1005 Edwards Ct.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Shirley Middle Dale Last Black
4. DATE OF DEATH: Month 10 Day 29 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-10-39
9. AGE (last birthday): 20
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): I-B-M operator
10b. KIND OF BUSINESS OR INDUSTRY: State Farm Ins Co.
11. BIRTHPLACE (City and state or country): Columbia Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: James A. Black
13b. MOTHER'S MAIDEN NAME: Thelma Hopper
14. NAME OF HUSBAND OR WIFE:
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. 492-44-8401
17. INFORMANT: James A. Black Address: Columbia Mo

MEDICAL CERTIFICATION

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)	Cerebral Vascular hemorrhage	10-5-59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Acute myelogenous Leukemia	10-29-59
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Clotting defect

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 10-10-59, to 10-29-59 and last saw her alive on 10-29-59
Death occurred at 12:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Michael J. Anziani M.D.
22b. ADDRESS U. of Mo. Med Center
22c. DATE SIGNED 10-29-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10/31/1959
23c. NAME OF CEMETERY OR CREMATORY Memorial Park
23d. LOCATION (City, town, or county) (State) Columbia, Mo.

24. FUNERAL DIRECTOR Lyman Funkhouser ADDRESS Columbia, Mo
25. DATE RECD. BY LOCAL REG. Oct 31 1959
26. REGISTRAR'S SIGNATURE Mrs. R E Palmer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

NOV 10 1958

STATEMENT BY LICENSED EMBALMER

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

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed George D. Rammel

Signature of Student Embalmer

Licensed Embalmer No. 442 S

P. O. Address Columbus

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