

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035168

FILED VS. NOV 2 1959 38

3006

530

STATE FILE NUMBER

RECEIVED

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

1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Length of stay in 1b 2 days		c. CITY OR TOWN Columbia		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION U of M. Medical Center			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rt 4		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Archie Turner Chouteau				4. DATE OF DEATH Month Day Year 10-29-59									
5. SEX MALE		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-20-95		9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY Industrial Lab.				11. BIRTHPLACE (City and state or country) Boone county Mo. U.S.A.		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME Samuel A. Chouteau				13b. MOTHER'S MAIDEN NAME Minnie Calvin				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) No				16. SOCIAL SECURITY NO. 496-05-2037		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) SUBARACHNOID HEMORRHAGE										INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSION										?			
DUE TO (c)													
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 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 Month, Day, Year a.m. p.m.													
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 10-27-59 to 10-29-59 and last saw him alive on 10-29-59 Death occurred at 1:05 P on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE J S Sanders (Degree or title) MD						22b. ADDRESS Univ. of Mo. Med Center			22c. DATE SIGNED 10/29/59				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-1-1959		23c. NAME OF CEMETERY OR CREMATOR Old Union		23d. LOCATION (City, town, or county) (State) Columbia Route 4, Mo.							
24. FUNERAL DIRECTOR Lyman Sprinkle ADDRESS Columbia, Mo.				25. DATE RECD. BY LOCAL REG. Oct 31 1959		26. REGISTRAR'S SIGNATURE Miss R E Palmer							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 28 1950 SA

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 me
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George R. [Signature]

Licensed Embalmer No. 11125

P. O. Address Columbia,

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.