

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038907

FILED VS NOV 23 1959

38

3006

569

STATE FILE NUMBER

RECORDED

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

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>4 days</u>		c. CITY OR TOWN <u>Browning</u>		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>Medical University of Mo. Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Jean</u> Last <u>Creason</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1959</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-56</u>		9. AGE (last birthday) <u>3</u>		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) <u>minor</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Milan, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Robert Creason</u>				13b. MOTHER'S MAIDEN NAME <u>Veda Watson</u>				14. NAME OF HUSBAND OR WIFE _____							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, or unknown) (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Hospital Chart</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Cardiac Tamponade</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post-op Open Cardiotomy for closure of ventricular septal defect and patent ductus</u>										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 type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____				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 <u>Nov 16, 1959</u> to <u>Nov 20, 1959</u> and last saw her/him alive on <u>Nov 20, 1959</u> Death occurred at <u>8:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>Roy August Wederfeld MD</u>						22b. ADDRESS <u>University of Mo. Medical Center</u>				22c. DATE SIGNED <u>11/20/59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)							
<u>Removal</u>		<u>11-21-59</u>		<u>Browning</u>				<u>Mo</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Peckers Funeral Service Columbia Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 20 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>									

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

Student _____
Signature of Student Embalmer

Signed Paul L. Fanning

Licensed Embalmer No. 7412

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.