DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-000595

FILED VS FEB 15 1960 53

Registration District No. _____ Primary Registration District No. 3010 Registrar's No. 60

STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Cape Girardeau — Length of stay in 1b: 6 hrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St.Francis Hosp. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: Cape Girardeau
c. CITY OR TOWN: Cape Girardeau — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1000 No.Clark Ave. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: William — Last: Statler

4. DATE OF DEATH: Month: February — Day: 6 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2/06/60

9. AGE (last birthday) — IF UNDER 1 YEAR: Months: ___ Days: ___ — IF UNDER 24 HR: Hours: 6 Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Cape Girardeau,Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Charles Wm.Statler Sr.

13b. MOTHER'S MAIDEN NAME: Alice Sue Smith

14. NAME OF HUSBAND OR WIFE: Ø

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: Charles W.Statler Sr. — Address: Cape Gir.Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Hyaline Membrane Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Prematurity

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. ☐ 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 2/6/60, to 2/6/60 and last saw ~~her~~ him alive on 2/6/60

Death occurred at 2:25 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Grant M. Hoxworth M.D.

22b. ADDRESS: 24 N. Spring Cape Girardeau Mo.

22c. DATE SIGNED: 2/10/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2/07/1960

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City, town, or county) (State): Cape Girardeau,Mo.

24. FUNERAL DIRECTOR ADDRESS: L. L. Haman-Cape Girardeau,Mo.

25. DATE RECD. BY LOCAL REG.: 2-12-1960

26. REGISTRAR'S SIGNATURE: Irene Karten

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Howard L. Herman

Signature of Student Embalmer

Licensed Embalmer No. 4122

P. O. Address Cape Girard

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