

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS FEB 23 1960

**-60-005120**  
STATE FILE NUMBER

Registration District No. **38** Primary Registration District No. **3006** Registrar's No. **94**

1. PLACE OF DEATH a. COUNTY <b>Boone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Boone</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>1 week</b>	c. CITY OR TOWN <b>Centralia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Boone County</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>East Rodemyre</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lelia</b> Middle <b>DeJarnatt</b> Last <b>DeJarnatt</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>15</b> Year <b>60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/1889</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>near Stuttgart, Ark</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James R. DeJarnatt</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Lee Stevinson</b>		14. NAME OF HUSBAND OR WIFE <b>never married</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT Address <b>Miss Ora Palmer, Centralia, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMOCOCCAL MENINGITIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		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 checked="" 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 checked="" 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 <b>2-9-1960</b> to <b>2-15-1960</b> and last saw her/him alive on <b>2-15-1960</b> Death occurred at <b>9:20 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>John H. Walters, M.D.</b>			22b. ADDRESS <b>22 N 2nd Columbia, Mo.</b>		22c. DATE SIGNED <b>2-16-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 17, '60</b>	23c. LOCATION (City, town, or county) <b>Centralia, Mo.</b>	23d. LOCATION (City, town, or county) (State) <b>Centralia, Mo.</b>			
24. FUNERAL DIRECTOR <b>Bill J. Madon Centralia, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>Feb. 16 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>			

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 Bill J. Meador

Licensed Embalmer No. 4876

P. O. Address Centralia, WA

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.