

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

**-60-006069**

**FILED VS FEB 29 1960**

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 35 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in 1b <u>hrs</u>	c. CITY OR TOWN <u>Tomona</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>Memorial Hosp</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rep 2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Bob Lee Middle Due Last Due 4. DATE OF DEATH 2-20-60 Month 2 Day 20 Year 60

5. SEX m 6. COLOR OR RACE w 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 9-23-31 28 9. AGE (last birthday) 28 10. IF UNDER 1 YEAR Months    Days    11. IF UNDER 24 HR Hours    Min.   

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 10b. KIND OF BUSINESS OR INDUSTRY    11. BIRTHPLACE (City and state or country) West Plains Mo 12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Geeter Due 14. MOTHER'S MAIDEN NAME Cecil Drumming et Howell Due 15. NAME OF HUSBAND OR WIFE   

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) yes 16. SOCIAL SECURITY NO.    17. INFORMANT Howell Due Tomona Mo 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) Cerebral concussion and hemorrhage INTERVAL BETWEEN ONSET AND DEATH 5 hours  
DUE TO (b) Fractured skull 5 hours  
DUE TO (c)     
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.) Automobile accident

20c. TIME OF INJURY Hour 3:45 a.m. Month, Day, Year 2 20 60

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.) Highway 20f. CITY, TOWN, OR LOCATION West Plains COUNTY Howell STATE Mo

21. I attended the deceased from 2/20/60 to 2/20/60 and last saw her alive on 2/20/60 8:30  
Death occurred at 8:20 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M.L. Fowler MD 22b. ADDRESS West Plains Mo 22c. DATE SIGNED 2/24/60

23a. BURIAL, CREMATION, REPOUND (Specify)    23b. DATE 2/23-60 23c. NAME OF CEMETERY OR CREMATORY Heuleberty 23d. LOCATION (City, town, or county) West Plains Mo (State)

24. FUNERAL DIRECTOR Robertson West Plains Mo ADDRESS    25. DATE RECD. BY LOCAL REG. 2-26-60 26. REGISTRAR'S SIGNATURE Beatrice Cook

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.