

# RID DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. AUG. 8 1960 128

Primary Registration District No. 2000

Registrar's No. 819

=60-026551  
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Laclede</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>12hrs.</b>		c. CITY OR TOWN <b>Lebanon</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>Burge-Protestant</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>New Buffalo Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Donna</b> Middle <b>Sue</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>1960</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>7-29-60</b>	9. AGE (last birthday) <b>18</b>	IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b>	IF UNDER 24 HR Hours <b>18</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>Lebanon, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Donald L. Smith</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Sue Bollinger</b>			14. NAME OF HUSBAND OR WIFE <b>none</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>none</b>		17. INFORMANT <b>Donald L. Smith, Lebanon, 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>Foetal atelectasis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Asmatary birth</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 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 <b>5:18</b> p.m.		Month, Day, Year <b>7-29-60</b>					
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 <b>Lebanon</b>		COUNTY <b>Mo.</b> STATE	
21. I attended the deceased from <b>7-29-60</b> to <b>7-30-60</b> and last saw her/him alive on <b>7-30-60</b> Death occurred at <b>5:18</b> P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Do not use title) <b>David D. Thomason</b>				22b. ADDRESS <b>6005 Lebanon</b>		22c. DATE SIGNED <b>8-4-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>8-2-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rose Memorial Park</b>		23d. LOCATION (City, town, or county) <b>Lebanon, Mo.</b>		23e. STATE	
24. FUNERAL DIRECTOR <b>D. Shady</b>			ADDRESS <b>Lebanon, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>8-5-60</b>	25. REGISTRAR'S SIGNATURE <b>Effie S. Melton</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 Gene C. Hunter

Licensed Embalmer No. 473

P. O. Address Spokane

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.