

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 5 1960

-60-041061  
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 674

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |                                                                                      |                                                                                                                                                          |                                                              |                                                                                      |                                                                                       |                                                                   |                                  |                                                                                                                                                                                 |  |                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>                    |                                                              |                                                                                      |                                                                                       |                                                                   |                                  |                                                                                                                                                                                 |  |                |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>                                                                                                                                                                                                                                                                                  |  | Length of stay in lb <u>12 Days</u>                                                                       |                                                                                      | c. CITY OR TOWN <u>CONWAY</u>                                                                                                                            |                                                              | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                                                                       |                                                                   |                                  |                                                                                                                                                                                 |  |                |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MO. MEDICAL CENTER</u>                                                                                                                                                                                                                                                |  |                                                                                                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                                                                                          | d. STREET ADDRESS (If outside, give location) <u>Route 2</u> |                                                                                      | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                   |                                  |                                                                                                                                                                                 |  |                |  |
| 3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>MARIE</u> Last <u>TOMALENAS</u>                                                                                                                                                                                                                                                                 |  |                                                                                                           |                                                                                      | 4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>60</u>                                                                                            |                                                              |                                                                                      |                                                                                       |                                                                   |                                  |                                                                                                                                                                                 |  |                |  |
| 5. SEX <u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                               |  | 6. COLOR OR RACE <u>White</u>                                                                             |                                                                                      | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |                                                              | 8. DATE OF BIRTH <u>11-7-27</u>                                                      |                                                                                       | 9. AGE (last birthday) <u>33</u>                                  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                                       |  | IF UNDER 24 HR |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FACTORY WORKER</u>                                                                                                                                                                                                                                                  |  |                                                                                                           |                                                                                      | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |                                                              |                                                                                      |                                                                                       | 11. BIRTHPLACE (City and state or country) <u>CONWAY Mo.</u>      |                                  | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>                                                                                                                                         |  |                |  |
| 13a. FATHER'S NAME <u>Wige Owens</u>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |                                                                                      | 13b. MOTHER'S MAIDEN NAME <u>MARY PERRYMAN</u>                                                                                                           |                                                              |                                                                                      |                                                                                       | 14. NAME OF HUSBAND OR WIFE <u>BERNARD TOMALENAS</u>              |                                  |                                                                                                                                                                                 |  |                |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                           |  |                                                                                                           |                                                                                      | 16. SOCIAL SECURITY NO. <u>497-22-7125</u>                                                                                                               |                                                              |                                                                                      |                                                                                       | 17. INFORMANT <u>UNIVERSITY OF MO. MEDICAL RECORDS</u><br>Address |                                  |                                                                                                                                                                                 |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>COR Pulmonale - Chronic, Severe</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Obstructive Emphysema</u><br>DUE TO (c) <u>Chronic Bronchietis &amp; Asthma</u> |  |                                                                                                           |                                                                                      |                                                                                                                                                          |                                                              |                                                                                      |                                                                                       |                                                                   |                                  | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                |  |                |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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 <u>5</u> a.m. p.m.                                                                                                                                                                                                                                                                                                                        |  | Month, Day, Year <u>11-30-60</u>                                                                          |                                                                                      |                                                                                                                                                          |                                                              |                                                                                      |                                                                                       |                                                                   |                                  |                                                                                                                                                                                 |  |                |  |
| 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 <u>CONWAY MO</u>                                                                                                            |                                                              | COUNTY                                                                               |                                                                                       | STATE                                                             |                                  |                                                                                                                                                                                 |  |                |  |
| 21. I attended the deceased from <u>11-30-60</u> to <u>11-30-60</u> and last saw her/him alive on <u>11-30-60</u><br>Death occurred at <u>5 15</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                                   |  |                                                                                                           |                                                                                      |                                                                                                                                                          |                                                              |                                                                                      |                                                                                       |                                                                   |                                  |                                                                                                                                                                                 |  |                |  |
| 22a. SIGNATURE (Doctor or title) <u>Mois Gordon M.D.</u>                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |                                                                                      |                                                                                                                                                          |                                                              | 22b. ADDRESS <u>Univ. Hosp. Columbia, Mo</u>                                         |                                                                                       |                                                                   | 22c. DATE SIGNED <u>11-30-60</u> |                                                                                                                                                                                 |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>                                                                                                                                                                                                                                                                                                           |  | 23b. DATE <u>11-30-1960</u>                                                                               |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY <u>CONWAY</u>                                                                                                         |                                                              |                                                                                      |                                                                                       | 23d. LOCATION (City, town, or county) (State) <u>CONWAY MO</u>    |                                  |                                                                                                                                                                                 |  |                |  |
| 24. FUNERAL DIRECTOR <u>BARBER EDWARDS MARSHFIELD</u>                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |                                                                                      | ADDRESS                                                                                                                                                  |                                                              | 25. DATE RECD. BY LOCAL REG. <u>Dec 2, 1960</u>                                      |                                                                                       | 26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>                  |                                  |                                                                                                                                                                                 |  |                |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 17 1961

MS DEC 21 1960 SAT

**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 *R. W. Brown*

Licensed Embalmer No. 38

P. O. Address *W. H. Brown*

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.