RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-041336

LED VS NOV 1 6 1960

DED

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 189

STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: Cass
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Mt Pleasant Township
Length of stay in 1b: ---
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 328th USAF Hospital Richards-Gebaur AFB, Mo.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Hickman Mills
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 10816 Hillcrest Rd
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Baby Girl Middle: Last: Rothley

4. DATE OF DEATH: Month: November Day: 9 Year: 1960

5. SEX: Female

6. COLOR OR RACE: Cau

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8 Nov 60

9. AGE (last birthday): ---
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: 4 Min.: 54

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

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (City and state or country): Missouri

12. CITIZEN OF WHAT COUNTRY: United States

13a. FATHER'S NAME: Albert L. Rothley

13b. MOTHER'S MAIDEN NAME: Fern Troby

14. NAME OF HUSBAND OR WIFE: ---

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.: ---

17. INFORMANT: Albert L. Rothley
Address: 10816 Hillcrest Hickman Mills, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Repiratory insufficiency	5 Hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Prematurity	5 Hrs
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 8 November 1960, to 9 November 1960 and last saw her alive on 9 November 1960.
Death occurred at 12:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Raymond V. Hellweg M.D.

22b. ADDRESS: 328th USAF Hospital Richards-Gebaur AFB, Mo.

22c. DATE SIGNED: 9 Nov 60

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

23b. DATE: 11/10/1960

23c. NAME OF CEMETERY OR CREMATORY: Belton Cemetery

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

24. FUNERAL DIRECTOR: E. K. George & Sons
ADDRESS: Belton, Mo.

25. DATE RECD. BY LOCAL REG.: Nov-10-1960

26. REGISTRAR'S SIGNATURE: Mrs. Ray Lebrun

(Licensed Embalmer's Statement on Reverse Side)

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 b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Richard E. George

Signature of Student Embalmer

Licensed Embalmer No. 3958

P. O. Address Belton, M

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