

JRI DIVISION OF HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

=60-045123

OFFICE OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 687

FILED VS DEC 19 1960

NDED
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Miller</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Length of stay in 1b <u>10 days</u>		c. CITY OR TOWN <u>St. Elizabeth</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>University of Mo. Medical Center</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>R # 1.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sohn</u> Middle <u>Walter</u> Last <u>Doubikow</u>			4. DATE OF DEATH Month <u>12</u> - Day <u>11</u> - Year <u>60</u>				
5. SEX <u>Male</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>3-1-83</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (City and state or country) <u>St. Elizabeth</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Thomas Doubikow</u>			13b. MOTHER'S MAIDEN NAME <u>Ellen Hensley</u>			14. NAME OF HUSBAND OR WIFE <u>Annie Doubikow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>309-60-100</u>		17. INFORMANT <u>Medical Records - Medical Center</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissminated Cancer of the Prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
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 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 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 <u>21 August 60</u> to <u>11 December</u> and last saw her alive on <u>11 December 1960</u> Death occurred at <u>1205</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Jan W. Thompson MD</u> (Degree or title)				22b. ADDRESS <u>University Hospital</u>		22c. DATE SIGNED <u>12-15-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Dec. 14, 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Livingston Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Livingston Missouri</u>		
24. FUNERAL DIRECTOR <u>J. A. Humphrey</u> (Address) <u>Livingston Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Dec 11 1960</u>		REGISTRAR'S SIGNATURE <u>Mrs R E Palmox</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 J. G. Humphrey

Licensed Embalmer No. 4772

P. O. Address Oberlin, Ind.

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