

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009587

STATE FILE NUMBER

AMENDED

Registration District No. 283 Primary Registration District No. 5655 Registrar's No. 23

FILED MAR 23 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>LAWRENCE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>RHELPS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MT. VERNON</u>		Length of stay in 1b <u>3 mos. 6 days</u>	c. CITY OR TOWN <u>ROLLA</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MISSOURI STATE SANATORIA</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>401 MAIN</u>
3. NAME OF DECEASED (Type or print) First <u>HUBERT</u> Middle <u>RAY</u> Last <u>COLLIER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>67</u>
13a. FATHER'S NAME <u>ROBERT COLLIER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY C. CAMPBELL</u>	11. BIRTHPLACE (City and state or country) <u>DENT CO.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INSUFFICIENCY</u>		17. INFORMANT <u>MOTHER</u> Address <u>SAME</u>	
DUE TO (b) <u>RT. VENTRICULAR HYPERTROPHY & COR PULMO.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>	
DUE TO (c) <u>NAFE</u>		2 YRS. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MULTIPLE MYELOMA</u>		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 <u>5:45</u> a.m. p.m. Month, Day, Year <u>Dec. 15, 1960</u>	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>Dec. 15, 1960</u> to <u>March 19, 1961</u> and last saw <u>him</u> alive on <u>MARCH 19, 1961</u> . Death occurred at <u>5:45</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. Vernon Lang, M.D.</u>		22b. ADDRESS <u>MISSOURI STATE SANATORIA</u>	22c. DATE SIGNED <u>3-19-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3-20-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rolla Semetary</u>	23d. LOCATION (City, town, or county) (State) <u>Rolla Mo</u>
24. FUNERAL DIRECTOR <u>Max Z. Fossett</u> ADDRESS <u>Mt. Vernon</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-61</u>	26. REGISTRAR'S SIGNATURE <u>H. D. Fossett</u>

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William B. Connett

Licensed Embalmer No. 4850

P. O. Address Republic, J.

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.