

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016321

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 145 STATE FILE NUMBER

AMENDED

**FILED JUN 5 1961**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Adair</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in lb	c. CITY OR TOWN <b>Kirksville</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>Grim-Smith Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>, 211-N-Baltimore</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <b>JANET</b> Middle <b>ELLEN</b> Last <b>FLASPOHLER</b>			<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>28</b> Year <b>1961</b>	
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5-28-61</b>	<b>9. AGE (last birthday)</b> Months <b>0</b> Days <b>0</b>	<b>IF UNDER 1 YEAR</b> Hours <b>16</b>	<b>IF UNDER 24 HR</b> Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (City and state or country) <b>Kirksville, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
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<b>13a. FATHER'S NAME</b> <b>Ronald Flaspohler</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Helen Morrison</b>		<b>14. NAME OF HUSBAND OR WIFE</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) -----		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT</b> Address <b>Ronald Flaspohler, Kirksville, Mo.</b>	
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neurocirculatory Collapse</u> DUE TO (b) <u>Cerebral Anoxia</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 Hrs</u>  <u>16 Hrs</u>
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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"/> N. <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
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<b>20c. TIME OF INJURY</b>	Hour a.m. p.m.	Month, Day, Year			
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY	STATE
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21. I attended the deceased from 5-28-61 to 5-28-61 and last saw her alive on 5-28-61  
 Death occurred at 6:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Edward M. Green, M.D.</u>		<b>22b. ADDRESS</b> <u>Kirksville, Mo.</u>		<b>22c. DATE SIGNED</b> <u>5-29-61</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <u>5-29-1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Josephs Cemetery Salisbury, Mo.</u>		<b>23d. LOCATION</b> (City, town, or county) (State)	
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Davis &amp; Davis, Kirksville, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>May 29, 1961</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Doris W. Raloff</u>	
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INSTEAD OF

SHOULD READ

ITEM NO.

EDWARD M. GRIM, M.D.

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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirksville, Mo.

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.