SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

61-020327
STATE FILE NUMBER

AMENDED

FILED JUN 23 1961

Registration District No. 27 Primary Registration District No. 3605 Registrar's No. 80

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.

DOCUMENT BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Bates
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Butler, Mo.
Length of stay in 1b: 7 hrs
c. FULL NAME OF HOSPITAL OR INSTITUTION: Memorial Bates Co. Hosp.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Bates
c. CITY OR TOWN: Butler
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Inft.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Cynthia Leah Everman
4. DATE OF DEATH Month Day Year: June 12, 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-12-61
9. AGE (last birthday) | 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): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): Butler, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Loren CLeo Everman
13b. MOTHER'S MAIDEN NAME: Barbarba Jean Basham
14. NAME OF HUSBAND OR WIFE: NONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Loren Everman-Grandview Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
INTERVAL BETWEEN ONSET AND DEATH: 6 hours
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. ☐ 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 June 12/61 to and last saw her/him alive on June 12 1961
Death occurred at 10:15PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul H. Green D.O.
22b. ADDRESS: Harrisonville, Mo.
22c. DATE SIGNED: 6-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 6/13/61
23c. NAME OF CEMETERY OR CREMATORY: Richman
23d. LOCATION (City, town, or county) (State): Mo.

24. FUNERAL DIRECTOR: Culver Underwood
ADDRESS: Butler, Mo.
25. DATE RECD. BY LOCAL REG.: June 19-61
26. REGISTRAR'S SIGNATURE: Kendall Kerry

(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 me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.