

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020366

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 420

FILED JUL 10 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		c. CITY OR TOWN <u>Columbia</u>	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>509 Oak Street</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type in full) First Middle Last <u>Samuel Eugene Cheers</u>			4. DATE OF DEATH Month Day Year <u>7 2 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1961</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min. <u>5 57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Columbia Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>Henry Cheers</u>		13b. MOTHER'S MAIDEN NAME <u>Pauline Willson</u>		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT <u>Pauline Cheers</u>	
				Address <u>509 Oak Street</u>	

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) <u>Prenatal Prematurity (27 weeks)</u>			
DUE TO (b) <u>Placental degeneration</u>			
DUE TO (c) <u>Maternal Hypertension</u>			
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
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21. I attended the deceased from 9:48 Am. July 2, 1961 and last saw him alive on July 2, 1961
Death occurred 3:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William B. See M.D.</u>		22b. ADDRESS <u>Prof Bldg. Columbia Mo.</u>		22c. DATE SIGNED <u>7/2/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/3/61</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board Columbia Mo.</u>		23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR <u>Robert D. Johnston</u>	ADDRESS <u>Columbia Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>July 3, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>
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DATE AMENDED

PROPERTY OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

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 _____

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.