

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035844

STATE FILE NUMBER

AMENDED

FILED OCT 16 1961 Primary Registration District No. 3006 Registrar's No. 624

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>2 hrs</u>	c. CITY OR TOWN <u>Columbia</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>705 North 6th St.</u>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Atkins</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16 1860</u>
9. AGE (last birthday) <u>901</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>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Callaway County Mo. U S A</u>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>John Atkins</u>	13b. MOTHER'S MAIDEN NAME <u>Betsy</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>Roger Hall</u>		Address <u>Columbia RFD 700</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>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</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) <u>unhealed fracture, left hip.</u>			PART III. If deceased was female was there a pregnancy in last 90 days? <input type="checkbox"/> Yes <input checked="" 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 checked="" 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>10/7/61</u> to <u>10/12/61</u> and last saw him alive on <u>10/10/61</u> Death occurred at <u>2:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>B. U. Hamilla, II, M. D.</u>		22b. ADDRESS <u>1504 E. Broadway</u>	22c. DATE SIGNED <u>10/12/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 14 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Salem Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ashland Mo</u>
24. FUNERAL DIRECTOR <u>Burnett Funeral Home</u>		ADDRESS <u>Ashland Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 13 1961</u>
26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</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 W<sup>m</sup> C. Burnett

Licensed Embalmer No. 3564

P. O. Address Ashtland 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.