

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-040134

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No. 3001a

Registrar's No. 707

FILED DEC 4 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>Iron</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>8 days</u>		c. CITY OR TOWN <u>Arcadia</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt. #1</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Mary</u> Last <u>Spivey</u>				4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-14</u>		9. AGE (last birthday) <u>47</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>Cooks Station</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William W. Barr</u>			13b. MOTHER'S MAIDEN NAME <u>Lozeta Talbert</u>			14. NAME OF HUSBAND OR WIFE <u>Ben Spivey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>University of Missouri Medical Center</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>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>PATENT DUCTUS ARTERIOSUS</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>23 YEARS</u> <u>14 YEARS</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 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 _____ 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 _____			
21. I attended the deceased from <u>NOV. 17, 1961</u> to <u>NOV. 24, 1961</u> and last saw her alive on <u>NOV. 24, 1961</u> Death occurred at <u>11:20 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Robert W. Moellhoff, M.D.</u>				22b. ADDRESS <u>Univ. of Mo. Med Center Columbia</u>		22c. DATE SIGNED <u>11-25-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov. 25, '61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Cem. Viburnum Mo</u>		23d. LOCATION (City, town, or county) (State) <u>Ironton Mo</u>			
24. FUNERAL DIRECTOR <u>Charles Bruce Service Columbia, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>NOV 25 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NFC 6 1967

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,

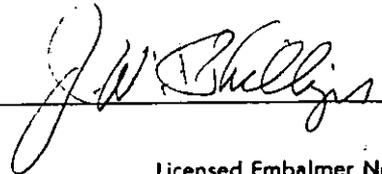
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 4897

P. O. Address Columbus Ms

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.