

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043022

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11123

**FILED DEC 12 1961**

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
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)		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
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>Atelectasis of lungs</u> DUE TO (b) _____ DUE TO (c) <u>762.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <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		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	
21. I attended the deceased from <u>11-20-61</u> to <u>11-21-61</u> and last saw <u>her</u> alive on <u>11-21-61</u> Death occurred at <u>2:00</u> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED	
22a. SIGNATURE (Name or title) <u>Paul M. Smith, M.D., M.S.</u>		22b. ADDRESS <u>2601 N. Whittier</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE			

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

Rowland Mortuary Svc. 4104-06 Manchester NOV 30 1961 Paul Smith, M.D.

FILED NO. 10-11-11

DATE

TIME

IF EMBALMED

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.

Signature of Licensed Embalmer

Signed \_\_\_\_\_

10-11-11

Signature of Licensed Embalmer

**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.

x

Student \_\_\_\_\_

Signed \_\_\_\_\_

Signature of Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

10-11-11

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.

10-11-11