

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043120

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3247 STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY St. Louis County
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Manchester, Mo. Length of stay in 1b 9 Months
 c. CITY OR TOWN Coggon Inside Limits Yes No
 d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pine Crest Homes Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) Unknown Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Alan Middle Robert Last Dighton 4. DATE OF DEATH Month Nov. Day 15 Year 61

5. SEX M. 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 10/30/57 9. AGE (last birthday) 4 yrs. 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) Houston, Texas 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Robert Dighton 13b. MOTHER'S MAIDEN NAME Mabel Hanbalin 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 Pine Crest Nursing Home, Manchester, Mo. 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) Cerebral Palsy INTERVAL BETWEEN ONSET AND DEATH Congenital
 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) Epilepsy, Grand Mal Type 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 NONE 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 2-25-61 to 11-15-61 and last saw her alive on 11-13-61
 Death occurred at 6:55 A.M. 11-15-61 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Allen McNearney M.S. 22b. ADDRESS 4308 E. Peter 22c. DATE SIGNED 11-16-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 11/16/61 23c. NAME OF CEMETERY OR CREMATORY Coggon Cemetery 23d. LOCATION (City, town, or county) (State) Coggon, Iowa

24. FUNERAL DIRECTOR Louis H. Bopp, Inc., Kirkwood, Mo. ADDRESS 11-16-61 25. DATE RECD. BY LOCAL REG. 11-16-61 26. REGISTRAR'S SIGNATURE James C. Murphy M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Francis J. Wyland Jr

Licensed Embalmer No. 4512

P. O. Address Richwood, W. Va.

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.