

Dr. **C. L. Palchuff**
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-022547

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 939c

FILED JUL 2 1962

VS 300
 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | Length of stay in 1b | c. CITY OR TOWN West Plains |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Lebo Route |
| 3. NAME OF DECEASED (Type or print) First Middle Last VICKI Lyn ASBERRY | | 4. DATE OF DEATH Month Day Year JUNE 14 1962 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH June 7, 1962 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of year Infant even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Infant | 11. BIRTHPLACE (City and state or country) West Plains, Missouri |
| 13a. FATHER'S NAME Virgil Asberry | | 13b. MOTHER'S MAIDEN NAME Jane White | 14. NAME OF HUSBAND OR WIFE X |
| 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. NO | 17. INFORMANT Address Mrs. Jane Asberry, West Plains, Mo |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis + gangrene of intestine DUE TO (b) Partial rotation (volvulus) of ileal cecal gut DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hirschsprung's Disease | | | 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 | |
| 21. I attended the deceased from <u>6/10/62</u> to <u>6/14/62</u> and last saw <u>her</u> alive on <u>6/14/62</u> Death occurred at <u>4:12 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) C. L. Palchuff MD | | 22b. ADDRESS Springfield, Mo. | 22c. DATE SIGNED 6/25/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 6-14-62 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) West Plains, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO. | | 25. DATE RECD. BY LOCAL REG. 6-27-62 | 26. REGISTRAR'S SIGNATURE Effie E. Nelder |

C. L. Palchuff
 USE BLACK INK OR TYPEWRITER RIBBON
 nu 2-4433

1936 S. Clinton

Permit renewed 6-10-63

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 Lucian T. Swadley

Licensed Embalmer No. 4815

P. O. Address Springfield, 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.