

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-046498

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1819

STATE FILE NUMBER

<p>FILED JAN 14 1963</p> <p>GREENE</p>		<p>1. PLACE OF DEATH a. COUNTY GREENE</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY GREENE</p>							
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD</p>		<p>Length of stay in 1b 45 Min.</p>		<p>c. CITY OR TOWN SPRINGFIELD</p>		<p>Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>					
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital</p>			<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>d. STREET ADDRESS (If outside, give location) RFD#8 Box 517A</p>		<p>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED First Middle Last NEWBORN GIRL BARBEE</p>				<p>4. DATE OF DEATH Month Day Year December 7, 1962</p>							
<p>5. SEX Female</p>		<p>6. COLOR OR RACE White</p>		<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 12/7/62</p>		<p>9. AGE (last birthday) 0</p>		<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 0 0 0 45</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY Infant</p>		<p>11. BIRTHPLACE (City and state or country) Springfield, Mo.</p>		<p>12. CITIZEN OF WHAT COUNTRY USA</p>			
<p>13a. FATHER'S NAME Ray Edward Barbee</p>				<p>13b. MOTHER'S MAIDEN NAME Loretta Boyer</p>				<p>14. NAME OF HUSBAND OR WIFE Never Married</p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No</p>				<p>16. SOCIAL SECURITY NO. No</p>		<p>17. INFORMANT Loretta Barbee (Mother) Springfield, Mo.</p>		<p>Address RFD#8</p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>								<p>INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>IMMEDIATE CAUSE (a) Extreme immaturity (5½ mo. pregnancy)</p>											
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>								<p>DUE TO (b) _____</p>			
<p>DUE TO (c) _____</p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>								<p>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</p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>							
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>											
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION</p>		<p>COUNTY</p>		<p>STATE</p>			
				<p>21. I attended the deceased from 12/7/62 to 12/7/62 and last saw her alive on 12/7/62</p>							
				<p>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p>22a. SIGNATURE <i>Walter A. German, M.D.</i> (Degree or title)</p>				<p>22b. ADDRESS 1211 S. Glenstone Springfield Missouri</p>		<p>22c. DATE SIGNED 1-4-63 (State)</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Retained at Hospital for Lab.</p>		<p>23b. DATE</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Burge Hospital</p>		<p>23d. LOCATION (City, town, or county) Springfield, Missouri</p>					
<p>24. FUNERAL DIRECTOR ADDRESS KLINGNER MORTUARY, INC. SPRINGFIELD Mo.</p>				<p>25. DATE RECD. BY LOCAL REG. 1-8-63</p>		<p>26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i></p>					

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
6397
2390
3
4 1
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7 0
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9776X
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13

ITEM NO. SHOULD READ

Burge Hospital Laboratory

None embalmed

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. _____

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.

NOT EMBALMED