

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007392

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 166 Primary Registration District No. 8605 Registrar's No. 7

FILED MAR 4 1963

VS 300  
Rev. 4/59

1 0510  
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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 <b>Johnson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>		Length of stay in 1b <b>15 min</b>	c. CITY OR TOWN <b>Whiteman Air Force Base</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>USAF Hospital WAFB, Mo</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 1, Knob Noster</b>
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Lee</b> Last <b>Buchanan</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Feb 63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>USAF Hospital Whiteman AFB, Mo</b>
13a. FATHER'S NAME <b>John W Buchanan, Jr.</b>		13b. MOTHER'S MAIDEN NAME <b>Gail R. McIntyre</b>	14. NAME OF HUSBAND OR WIFE <b>-</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>John W. Buchanan, Jr. Rt #1, Knob Noster Mo</b>
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>Spina Bifida</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)			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 <b>6:16 PM</b> to <b>6:30 PM</b> and last saw her <b>alive</b> on <b>23 February 1963</b> Death occurred at <b>6:30</b> P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write in ink) <b>ROBERT H DUEMLER, MD</b>		22b. ADDRESS <b>USAF Hospital Whiteman Air Force Base, Mo</b>	22c. DATE SIGNED <b>23 Feb 63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-26-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Knob Noster Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Knob Noster, Mo.</b>
24. FUNERAL DIRECTOR <b>The Brennigers, Warrensburg</b>		25. DATE RECD. BY LOCAL REG. <b>No. 7 Feb 25-63</b>	26. REGISTRAR'S SIGNATURE <b>Erma L. Beatty</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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. 3377

P. O. Address W. Hamburg, Pa.

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.