

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027222

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 483

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 19 1963

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>46 da</u>	c. CITY OR TOWN <u>Montgomery City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U of Mo Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>629 N. Walker</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>ANN</u> Last <u>Gaston</u>			4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1963</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-63</u>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <u>1</u> Days <u>16</u> IF UNDER 24 HR: Hours <u></u> Min. <u></u>	
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) <u>Columbia Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Peggy Jean Gaston</u>		14. NAME OF HUSBAND OR WIFE	
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 <u>U of Mo Medical Record Columbia Mo</u> address	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Tuber</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Bacterial</u>	
	DUE TO (c) <u>Exfoliative Dermatitis</u>	
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 checked="" 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.)	
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>		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.) <u>Columbia</u>	20f. CITY, TOWN, OR LOCATION <u>Boone</u>	STATE <u>Mo.</u>
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21. I attended the deceased from July 1, 1963 to July 12, 1963 and last saw her alive on July 12, 1963
Death occurred at 1:40 p.m. on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Ink or title) <u>James E. Taylor M.D. Univ. Hosp. Columbia, Mo</u>		22b. ADDRESS <u>Columbia, Mo</u>		22c. DATE SIGNED <u>July 12, 1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-13-1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sumner Memorial Gardens Montgomery City Mo</u>	
24. FUNERAL DIRECTOR <u>D B Baker New Flamer Mo</u>		25. DATE RECD. BY LOCAL REG <u>July 13, 1963</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

VS 300 Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

D B Baker

Licensed Embalmer No.

3375

P. O. Address

New France 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.