

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-027276**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 513

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED				
1 0109					
2 0150					
3					
4 0					
5 0					
6					
7 0					
8 1					
9 289.3					
10					
11					
12 2:0					
13 30					
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF:	ITEM NO. SHOULD READ

FILED JUL 29 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>CAMDEN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>COLUMBIA</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>MACKS CREEK</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>MEDICAL CENTER UNIVERSITY OF MO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRUCE DALE WILLIS</u>			4. DATE OF DEATH Month Day Year <u>7 24 1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>7-28-62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>11 24</u>
11. BIRTHPLACE (City and state or country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>CHARLES WILLIS</u>		13b. MOTHER'S MAIDEN NAME <u>VIRGINIA LEAP</u>	
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. <u>_____</u>	
17. INFORMANT <u>Hospital Records 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</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fibrous tissue Resection of Pleura</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 <u>7/23/63</u> to <u>7/24/63</u> and last saw <sup>him</sup> alive on <u>7/24/63</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James H. Burkholder M.D.</u>		22b. ADDRESS <u>Medical Center</u>	
22c. DATE SIGNED <u>7/24/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-26-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Buffalo, Missouri</u>	
24. FUNERAL DIRECTOR <u>Lyman Sprinkle, Columbia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>July 25 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmere</u>			

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 Lyman Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbiana, 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.