

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042897
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 844

FILED DEC 9 1963

DO NOT WRITE ON THIS STUB
AMENDED

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BOONE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		Length of stay in 1b <u>172 Days</u>	c. CITY OR TOWN <u>COLUMBIA</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>UNIVERSITY OF MISSOURI MEDICAL CENTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>510 LAUREL DRIVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ARCHIE CARL WAYNE</u> First Middle Last			4. DATE OF DEATH <u>DEC. 4, 1963</u> Month Day Year
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-23-15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIQUOR STORE</u>	9. AGE (last birthday) <u>48</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>BOONE COUNTY MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>CARL WAYNE (DECEASED)</u>		13b. MOTHER'S MAIDEN NAME <u>CORA LATTIMER</u>	
14. NAME OF HUSBAND OR WIFE <u>DIVORCED</u>		17. INFORMANT Address <u>UNIVERSITY OF MISSOURI MEDICAL CENTER - RECORD ROOM FILE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI UNKNOWN.</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Polyarteritis</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). <u>myocardial infarction</u> 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			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		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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.)	
21. I attended the deceased from <u>7 Jul 63</u> to <u>4 Dec 63</u> and last saw ^{her} _{him} <u>live on 4 Dec 63</u> Death occurred at <u>10:20 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>Harold J. Jones M.D.</u>		22b. ADDRESS <u>University of Missouri Medical Center, Columbia, Mo.</u>	
22c. DATE SIGNED <u>5 Dec 63</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-6-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>	23d. LOCATION (City, town, or county) <u>COLUMBIA, MISSOURI</u>
24. FUNERAL DIRECTOR <u>PARKER FUNERAL SERVICE COLUMBIA, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 6 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

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DEC 12 1963

DEC 18 1963

FEB 27 1964

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 J. Phillips
Licensed Embalmer No. 4897
P. O. Address Columbus, 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.