

FILED NOV 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36879

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1015

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <b>Springfield</b>		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>SPRINGFIELD</b>	
d. STREET ADDRESS (If rural, give location) <b>830 S. MISSOURI</b>		3. NAME OF DECEASED a. (First) <b>DONALD</b> b. (Middle) <b>LEE</b> c. (Last) <b>COTTER</b>	
4. DATE OF DEATH <b>NOV. 20, 1949</b>		5. SEX <b>MALE</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>INFANT</b>	
8. DATE OF BIRTH <b>JULY 21, 1946</b>		9. AGE (In years last birthday) <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>	
11. BIRTHPLACE (State or foreign country) <b>SPRINGFIELD, MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>ARTHUR COTTER</b>		13b. MOTHER'S MAIDEN NAME <b>ARABELL HICKS</b>	
14. NAME OF HUSBAND OR WIFE <b>SINGLE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NO.</b>		17. INFORMANT'S SIGNATURE OR NAME <b>ARTHUR COTTER</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. ADDRESS <b>SPFLD, MO.</b>	
18. CAUSE OF DEATH (continued) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Severe malnutrition, dehydration</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral oplosia - lndaryte with avouia</b> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH  <b>7950</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Nov 15<sup>th</sup></u> , 1949, to <u>Nov 20<sup>th</sup></u> , 1949, that I last saw the deceased alive on <u>Nov 20<sup>th</sup></u> , 1949, and that death occurred at <u>3:45 p. m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <b>Robert H. Friedman M.D.</b>		23b. ADDRESS <b>Burge Hospital</b>	
23c. DATE SIGNED <b>Nov 20, 1949</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24b. DATE <b>11-22-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>WHITE CHAPEL</b>	
24d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD MO.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Klingner &amp; Co</b>	
DATE REC'D BY LOCAL REG. <b>11-21-49 W.F. Handley</b>		REGISTRAR'S SIGNATURE <b>W.F. Handley M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Klingner &amp; Co</b>		ADDRESS <b>Springfield Mo.</b>	

**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.

Signed \_\_\_\_\_

*Mal Rhodes*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

4071

P. O. Address \_\_\_\_\_

*Springfield*

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 this body is not embalmed, fact should be so stated above.