

FILED MAY 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11804**
Registrar's No. **430**

BIRTH NO. **34425-54** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY WRIGHT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN MT. GROVE	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE Hospital		e. STREET ADDRESS (If rural, give location) 1141	
3. NAME OF DECEASED (Type or Print) a. (First) Mark b. (Middle) Alan c. (Last) Whittaker		4. DATE OF DEATH (Month) (Day) (Year) 4-29-54	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 4-25-54
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 Foreign Country) Mt Grove, Mo
13a. FATHER'S NAME David Whittaker		13b. MOTHER'S MAIDEN NAME Louise Head	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'S SIGNATURE OR NAME David Whittaker, Mt. Grove, Mo ADDRESS
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Plasmos Fatalis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7700	
21a. SUICIDE OR HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-29, 1954 to 4-29, 1954 , that I last saw the deceased alive on 4-29, 1954 , and that death occurred at 10:26 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Urban J. Busiek, MD		23b. ADDRESS Springfield Mo	
23c. DATE SIGNED 4-29-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-29-54	
24c. NAME OF CEMETERY OR CREMATORY Cabool Cemetery		24d. LOCATION (City, town, or county) (State) Cabool Missouri	
DATE REC'D BY LOCAL REG. 5-1-54		REGISTRAR'S SIGNATURE Edith Williamson	
		25. FUNERAL DIRECTOR'S SIGNATURE Elliot Lentz ADDRESS Cabool, Mo	

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

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

No embalming
Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.