

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3913

State File No. ....

BIRTH NO. W8 6604-55 REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 49

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, write RURAL and give township) <u>Columbia</u>		c. LENGTH OF STAY (in this place) <u>5 days</u>	c. CITY OR TOWN <u>Sturgeon</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		STREET ADDRESS (If rural, give location) <u>RDD #2</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Linda Kay</u> b. (Middle) <u>Maiden</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 26, 1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>Feb. 21, 1955</u>	9. AGE (in years last birthday) <u>5</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Columbia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>George Robert Maiden</u>	13b. MOTHER'S MAIDEN NAME <u>Pauline Hathman</u>	14. NAME OF HUSBAND OR WIFE <u>Infant</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- - - -</u>		16. SOCIAL SECURITY NO. <u>- - - -</u>
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Geo. R. Maiden, Sturgeon, Mo.</u>		

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, asthemia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CONGENITAL HEART DISEASE</u> <u>TRANSPOSITION OF THE GREAT VESSELS</u> <u>INTERVENTRICULAR SEPTAL DEFECT</u>		<u>Life</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>ERYTHROBLASTOSIS</u> DUE TO (c) <u>FETALIS</u>		<u>Life</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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)	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 2-21, 1955, to 2-26, 1955, that I last saw the deceased alive on 2-26, 1955, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Edward J. Washington M.D.</u> (Degree or title)	23b. ADDRESS <u>Columbia, Mo. 909 University Ave.</u>	23c. DATE SIGNED <u>2-26-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2/27/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>
DATE REC'D BY LOCAL REG. <u>Feb. 26, 1955</u>	REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Memorial Funeral Home, Columbia, Mo.</u>		

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 <sup>not</sup> embalmed  
by me, ~~only~~ ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Lyman S. Sprinkle*  
Licensed Embalmer No. *4013*

P. O. Address *Columbia,*

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.