

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25850

FILED AUG 13 1956

STATE FILE NUMBER

Registration District No. 379 Primary Registration District No. 4987 Registrar's No. 168

Health
Welfare
Public
Service

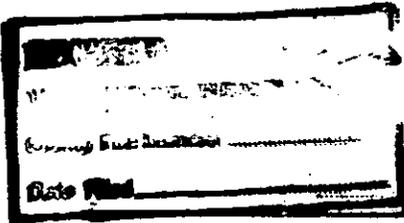
300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WRIGHT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>GASEONADE</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>MANSFIELD 1140</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>ENROUTE TO HOSP</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm <u>12 Miles N.W.</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RAHPH LEROY PLASTER</u> First Middle Last		4. DATE OF DEATH <u>July 27 1956</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Oct. 12, 1950</u>
9. AGE (In years last birthday) <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (City and state or country) <u>Hood River, Oregon U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>TOM PLASTER</u>		14. MOTHER'S MAIDEN NAME <u>Rose Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>TOM PLASTER</u>		Address <u>MANSFIELD MO</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>Probably Fractured SKULL.</u> <u>IN RIGHT TEMPLE</u> <u>RABBIT HUTCH FELL ON HIM.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>9100</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>22</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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 <u>10:30 a.m. 7-27-56</u> Hour 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.) <u>Home</u>	
20f. CITY, TOWN, OR LOCATION <u>114</u>		COUNTY STATE	
21. I viewed the deceased from <u>July 27, 56,</u> to _____ and last saw her alive on _____ Death occurred at <u>10:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Frank Leslie Currier</u> (Doctor or title)		22b. ADDRESS <u>114 N. Olive,</u>	
		22c. DATE SIGNED <u>7-27-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>AUG. 1-1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN</u>	23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>
24. FUNERAL DIRECTOR <u>Max & Miller</u>		25. DATE RECD. BY LOCAL REG. <u>8/3/56</u>	
ADDRESS <u>Mansfield Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Frank Currier</u>	

(Licensed Embalmer's Statement on Reverse Side)



RECEIVED *Aug. 6, 1956*
WRIGHT CO. HEALTH DEPT.
 County File Number *856-78*
 Date Filed *Aug 11, 1956*

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..... *Max L Miller*

Licensed Embalmer No. *478*

P. O. Address *Mansfield*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
 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.**