

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28032

STATE FILE NUMBER

 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 806-A

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CONWAY MO R2</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>BURGE</u>		Length of stay in lb <u>8 HRS</u>	d. STREET ADDRESS (If outside, give location) <u>10 MI. N. MARSHFIELD</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>REBECCA JANE MARLIN</u>			4. DATE OF DEATH Month Day Year <u>AUG 12 1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>FEB 22 - 1956</u>	9. AGE (In years last birthday) <u>17</u> Months <u>20</u> Days	IF UNDER 1 YEAR Hours Min. <u>17</u> <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>WAYNE MARLIN</u>		13b. MOTHER'S MAIDEN NAME <u>ELSA JANE LINDER</u>		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): <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>WAYNE MARLIN CONWAY MO R2</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. Probably an</u> <u>Overwhelming Upper Respiratory Infection</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>With renal insufficiency.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>475X</u>					INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>7:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>James P. Jones M.D. Health Officer Springfield, Mo.</u>			22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>8-20-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8-14-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST DUKE</u>		23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co MO</u>
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD MO</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-20-57</u>	26. REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *R. W. B. B.*

Licensed Embalmer No. *3848*

P. O. Address *1111 1/2 Ave. N. W.*

**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.**