

Health,  
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

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36512  
STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 105

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Lafayette</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Lexington</b> <u>0542</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 <b>Lex. Mem. Hosp.</b>			Length of stay in lb <b>8Hr.</b>		d. STREET ADDRESS (If outside, give location) <b>23rd. &amp; Franklin</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>BABY</b> <sup>First</sup> <b>GIRL</b> <sup>Middle</sup> <b>JUNGEBLUT</b> <sup>Last</sup>				4. DATE OF DEATH <b>October 25 1957</b> <sup>Month</sup> <sup>Day</sup> <sup>Year</sup>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 25 1957</b>		9. AGE (In years last birthday) <b>0</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>8</b> Min. <b>30</b>		IF UNDER 24 HRS. Hours <b>8</b> Min. <b>30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of year. <sup>None if retired</sup> ) <b>INFANT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state of country) <b>Lexington Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>LeRoy Jungeblut</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Long</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>LeRoy Jungeblut</b> Address <b>Lexington, Mo</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>prematurity - Birth weight 1 pound 5 oz</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>			
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 _____ 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 <b>October 25 1957</b> <b>Oct 25 1957</b> and last saw her <del>person</del> alive on <b>Oct 25 1957</b> Death occurred at <b>300</b> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Ralph W. Kelly, D</b> (Degree of Illness)						22b. ADDRESS <b>Lexington, Mo</b>			22c. DATE SIGNED <b>10-26-57</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 26, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Higginville, Mo</b>						
24. GENERAL DIRECTOR <b>Harold L. Walker, Lex. Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>Nov. 2, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Thomas Eastbrook</b>							

(Licensed Embalmer's Statement on Reverse Side)

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 *Harold L. Walker*

Licensed Embalmer No. 45

P. O. Address *Lex. Mo*

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.