

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024671

STATE FILE NUMBER

833

AUG 11 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

300  
1-57

3

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Nebraska</b> b. COUNTY <b>Sarpy</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>Fort Crook</b> <i>8 26 08</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>d.o.a. Mo. Methodist Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Mt. View T trailer Court</b>	
3. NAME OF DECEASED (Type or print) First <b>Lynn</b> Middle <b>Rivers</b> Last <b>Rivers</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>3,</b> Year <b>1958</b>	
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>July 3, 1946</b>
9. AGE (In years last birthday) <b>12</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lexington, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Charles Rivers</b>	
13b. MOTHER'S MAIDEN NAME <b>Nancy C. Cross</b>		14. NAME OF HUSBAND OR WIFE <b>none</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>Nancy Edwards</b>		Address <b>Mountainview Trailer Ft. Crook, Neb. Court</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>Traumatic shock &amp; Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>set once</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <b>Fractured skull &amp; nose</b>			
DUE TO (c) <b>Auto accident</b>			
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 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.) <b>Tire blew out on pickup truck in which child was riding and truck overturned</b>	
20c. TIME OF INJURY Hour <b>1:45</b> p.m. Month, Day, Year <b>8/3/58</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, store, street, office bldg., etc.) <b>U.S. Highway # 71</b>	
20e. CITY, TOWN, OR LOCATION <b>Buchanan</b> STATE <b>Mo.</b>		20f. CITY, TOWN, OR LOCATION <b>1 1/2 Miles south of St. Joseph, Mo.</b>	
21. I attended the deceased <b>on Aug. 3, 1958,</b> to <b>St. Joseph, Mo.</b> and last saw her alive on <b>Aug. 3, 1958</b> Death occurred at <b>1:45 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>G. Melaney, M.D.</b> (Degree or title)		22b. ADDRESS <b>St. Joseph, Mo. Goroner Kirkpatrick Bldg.</b>	
22c. DATE SIGNED <b>8/3/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/3/58</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Temple Funeral Home</b>		23d. LOCATION (City, town, or county) (State) <b>Lexington, Mo.</b>	
24. FUNERAL DIRECTOR <b>Clark a Clark</b> ADDRESS <b>Clark Funeral Home St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Aug 5, 1958</b>	
26. REGISTRAR'S SIGNATURE <b>Wm. Clark</b>			

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 *E. A. Clark* .....

Licensed Embalmer No. *4235* .....

P. O. Address *St. Joseph* .....

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.

*Removed to Temple Funeral Home, Lexington, Va*