

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035458

STATE FILE NUMBER

FILED NOV 3 1958

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 487

health, Welfare Public Service
300
1-56
0
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.
31
0

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Boone					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION University of Mo. Medical Center			Length of stay in lb 2 Days.		d. STREET ADDRESS (If outside, give location) 1212 WALNUT		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First HAROLD Middle PATRICK Last M^{rs} CORY				4. DATE OF DEATH Month 10 Day 30 Year 58					
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-06		9. AGE (In years last birthday) 52 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country) Audrain Co. Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John M^{rs} CORY				14. MOTHER'S MAIDEN NAME KATHERINE DUFFY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 488-18-8127		17. INFORMANT University of Mo. Medical Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Anoxia DUE TO (c) Pulmonary insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Histoplasmosis								INTERVAL BETWEEN ONSET AND DEATH 5 mins. 24 Hours 1 year	
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 <input type="checkbox"/> a. m. <input type="checkbox"/> p. m.									
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from Oct. 29, 1958 to Oct. 30, 1958 and last saw ^{her} alive on Oct. 29, 1958 Death occurred at 3:15 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) William D. Gaunt M.D.				22b. ADDRESS U. of Missouri Medical School		22c. DATE SIGNED Oct. 30, 1958			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 1, 1958	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM.		23d. LOCATION (City, town, or county) Columbia Mo		(State)		
24. FUNERAL DIRECTOR Parsons Funeral Service Columbia Mo				25. DATE RECD. BY LOCAL REG. Oct 30 1958		26. REGISTRAR'S SIGNATURE Mrs. R.E. Palmer			

1956 9 AON

MAY 26 1964

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.....
Licensed Embalmer No. 489
P. O. Address.....

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