

8

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038535

STATE FILE NUMBER

FILED NOV 10 1958 Registration District No. 324 Primary Registration District No. 307 Registrar's No. 176

1. PLACE OF DEATH a. COUNTY Saline			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall		Inside Limits Yes <input checked="" type="checkbox"/> NO	c. CITY OR TOWN Marshall		Inside Limits Yes <input checked="" type="checkbox"/> NO
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION John Fitzgibbon Hosp. 45min.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 529 E. Vest		Reside on Farm YES No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Robert Junior McKenzie			4. DATE OF DEATH Month Day Year November 5, 1958		
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1931	9. AGE (In years last birthday) 28	IF UNDER 1 YEAR Months Days 4 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Robert McKenzie		13b. MOTHER'S MAIDEN NAME Gertrude Williams		14. NAME OF HUSBAND OR WIFE none	
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.	17. INFORMANT Address Gertrude Williams, Marshall, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A Fall Fracture					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
DUE TO (b) _____ DUE TO (c) _____					
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 Hour Month, Day, Year 8:30 p.m. 11/5/58					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 529 E. Vest		20f. CITY, TOWN, OR LOCATION 097 COUNTY Saline STATE Missouri	
21. I attended the deceased from Nov. 5, 1958 to Nov. 5, 1958 and last saw him alive on Nov. 5, 1958 Death occurred at 10:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE James A. Reed MD (Sign as or title)			22b. ADDRESS Marshall Mo		22c. DATE SIGNED 11-7-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/9/58	23c. NAME OF CEMETERY OR CREMATORY Salt Pond Cemetery		23d. LOCATION (City, town, or country) (State) S.W. Saline County, Missouri
24. FUNERAL DIRECTOR George E. Green, Marshall Mo			25. DATE RECD. BY LOCAL REG. 11-8-58		26. REGISTRAR'S SIGNATURE Carl H. Reed

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 *Georgette Green*
Licensed Embalmer No. *4220*
P. O. Address *Marshall St*

8:30

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.