

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044548

STATE FILE NUMBER

92646-58

FILED JAN 13 1958

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 17

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <u>Independence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lamoni</u> <u>8140</u> <u>8</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Indep. Hospital</u>		Length of stay in 1b <u>—</u>	d. STREET ADDRESS (If outside, give location) <u>515 So Maple</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>A. Richard David</u> Middle <u>Ultican</u> Last <u>Ultican</u>			4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1958</u>		
--	--	--	--	--	--

5. SEX <u>Male</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>Dec. 27-1958</u>	9. AGE (In years last birthday) <u>17</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</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 <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Independence Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	--	--

13a. FATHER'S NAME <u>Gary Ultican</u>	13b. MOTHER'S MAIDEN NAME <u>Lynda Stapleton</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
---	---	--

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. <u>none</u>	17. INFORMANT <u>Gary Ultican</u> Address <u>Lamoni Iowa</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>Prematurity 4-4 1/2 mo</u>		INTERVAL BETWEEN ONSET AND DEATH
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) <u>776X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>12-27-58</u> to <u>12-27-58</u> and last saw him alive on <u>12-27-58</u> Death occurred at <u>a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Rand Beckman MD</u> (Degree or title)	22b. ADDRESS <u>Indep. Mo</u>	22c. DATE SIGNED <u>12-29-58</u>
--	----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 29-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Independence Mo</u>
--	--------------------------------	--	---

24. FUNERAL DIRECTOR <u>Poland R. Speaks</u> ADDRESS <u>Indep.</u>	25. DATE RECD. BY LOCAL REG. <u>12-29-58</u>	26. REGISTRAR'S SIGNATURE <u>James Lewis</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

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 ..... *Willie Kessel* .....

Licensed Embalmer No. *4690* .....

P. O. Address ..... *Indep. 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.