

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045195

STATE FILE NUMBER

93891-58
FILED JAN 9 1959

Registration District No. 290

Primary Registration District No. 5985

Registrar's No. 183

300
1-57

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|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Pulaski | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Fort Leonard Wood | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital | | Length of stay in lb -- | d. STREET ADDRESS (If outside, give location) US Army Hospital | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle JERRY Last EVELETH | | | 4. DATE OF DEATH Month December Day 13 Year 1958 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 13 Dec 1958 | | 9. AGE (In years last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 1 Hours 5 Min 5 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Robert D Eveleth | | 13b. MOTHER'S MAIDEN NAME Barbara Lois Curtis | | 14. NAME OF HUSBAND OR WIFE ----- | |
| 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 Robert D Eveleth | | Address St James, 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) Respiratory failure | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Prematurity | | | | | |
| DUE TO (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 7735 | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 13 Dec 58 to 13 Dec 58 and last saw ^{him} alive on 13 Dec 58 Death occurred at 7:30 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE H. Baruch (Degree or title) H. BARUCH Capt MC | | | 22b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri | | 22c. DATE SIGNED 15 Dec 58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| Burial | 12-17-58 | Park Cemetery | | Ft Leonard, Mo. | |
| 24. FUNERAL DIRECTOR Jesse Dehn - St. James, Mo | | ADDRESS | 25. DATE RECD. BY LOCAL REG. 12-17-58 | 26. REGISTRAR'S SIGNATURE Gula J. Anderson | |

(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

This body was not embalmed

Signed *C. Jesse Gahr*
Licensed Embalmer No. *4786*

P. O. Address *St. James, 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.