Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008424
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 128

1. PLACE OF DEATH
a. COUNTY Boone
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Columbia — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 210 St James — Length of stay in Hospital 2 mos

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Boone
c. CITY OR TOWN Columbia 0105 0 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 210 St James — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First CONNIE Middle MAC Last SIX

4. DATE OF DEATH Month MAR. Day 20 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH January 19, 1959
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 2 Days — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Columbia Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME CONNIE CALVIN SIX
13b. MOTHER'S MAIDEN NAME FRANCIS ATTERBERRY
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Mrs. CONNIE C. SIX, Address 210 St James Columbia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral acute — INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 491X
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 ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Coroner's Case and last saw her/him alive on
Death occurred at approx 7:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Vincent P Perna (Degree or title) MD
22b. ADDRESS Univ. of Mo. Med Center
22c. DATE SIGNED 20 Mar 59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/22/1959
23c. NAME OF CEMETERY ~~OR CREMATORY~~ Hillcrest
23d. LOCATION (City, town, or county) (State) Fulton, Mo.

24. FUNERAL DIRECTOR Thomas Franklin ADDRESS Columbia
25. DATE RECD. BY LOCAL REG. Mar 21 1959
26. REGISTRAR'S SIGNATURE Mrs. R. E. Palmer

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

1959

MAR 31 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was NOT embalmed ~~by me, or by~~ ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signed Lyman Sprinkle
Signature of Student Embalmer

Licensed Embalmer No. 4013

P. O. Address Columbia, Me

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.