Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-017367

STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 421 C

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY OR TOWN SPRINGFIELD — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) BURGE Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY PULASKI
c. CITY OR TOWN WAYNESVILLE — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) City — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First SANDRA Middle KAYE Last LONG

4. DATE OF DEATH Month APRIL Day 4 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-16-1959
9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months / Days 8 — 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) WAYNESVILLE, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME DWAYNE LONG
13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND OR WIFE NONE

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 Hospital Officials Address SPRINGFIELD, MO.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Fetal Atalectasis — INTERVAL BETWEEN ONSET AND DEATH 8 days
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 (a) 7625

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 4-17-59, to 4-24-59 and last saw her/him alive on 4-24-59
Death occurred at 2:30 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Don S Overend (Degree or title) M.D.
22b. ADDRESS Springfield, Mo.
22c. DATE SIGNED 5-21-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 4/26/59
23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill
23d. LOCATION (City, town, or county) (State) WRIGHT Co. MO.

24. FUNERAL DIRECTOR John Simpson ADDRESS Hartville, MO
25. DATE RECD. BY LOCAL REG. 5-22-59
26. REGISTRAR'S SIGNATURE Effie B. Mellon

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 embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 3848

P. O. Address .....

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