

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020401  
STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 285

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Boone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cooper</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Boonville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Medical Center</b>		Length of stay in 1b <b>23 Hr.</b>	d. STREET ADDRESS (If outside, give location) <b>209 First St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DANNY</b> Middle <b>RAY</b> Last <b>Lingo</b>			4. DATE OF DEATH Month <b>6</b> - Day <b>28</b> - Year <b>59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-56</b>		9. AGE (In years last birthday) <b>2 yr.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Boonville Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>RAY Clifford Lingo</b>		13b. MOTHER'S MAIDEN NAME <b>Margart Sedgwick</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT Address <b>Hospital Record</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cystic Fibrosis of Pancreas</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Electrolyte Imbalance</b>					<b>48 hr.</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)					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.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <b>July 14 58</b> , to <b>June 1959</b> and last saw <del>him</del> <sup>her</sup> alive on <b>June 28, 1959</b> Death occurred at <b>6:30</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or title) <b>George J Van Leeuwen</b>			22b. ADDRESS <b>Columbia Mo.</b>		22c. DATE SIGNED <b>6-29-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 1, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove</b>		23d. LOCATION (City, town, or county) (State) <b>Boonville Mo</b>
24. FUNERAL DIRECTOR <b>Hoodman &amp; Belle Boonville Mo</b>		25. DATE RECD. BY LOCAL REG. <b>June 29 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
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.

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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 *William W. Wood* .....

Licensed Embalmer No. *4539* .....

P. O. Address *Boonville, 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.