URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-020414
STATE FILE NUMBER

FILED JUL 13 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 296

ENDED

1. PLACE OF DEATH
a. COUNTY: Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Columbia — Length of stay in Hospital: 6 da
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: U. of Mo. Medical Center — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: Miller
c. CITY OR TOWN: Eldon — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): Gen. Del. — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Connie — Middle: Lavonne — Last: Willis
4. DATE OF DEATH: Month: July — Day: 3 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/22/57
9. AGE (last birthday): 1 yr. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HR: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): minor
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Jefferson City, Mo
12. CITIZEN OF WHAT COUNTRY: USA.
13a. FATHER'S NAME: Vaughn Willis
13b. MOTHER'S MAIDEN NAME: Roberta Leak
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Patients Chart — Address:

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): Respiratory Insufficiency
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Fibrocystic Disease of the Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (c): Heart Disease, secondary to Pulmonary Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): —
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

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 July 1, 1959, to July 3, 1959 and last saw her/him alive on July 3, 1959
Death occurred at 8 05 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Ray August Wederfeld (Degree or title) MD
22b. ADDRESS: University of Mo Med Center
22c. DATE SIGNED: July 3, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-5-1959
23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove
23d. LOCATION (City, town, or county) (State): Camden Co Mo

24. FUNERAL DIRECTOR: L B Jones — ADDRESS: Buffalo Mo
25. DATE RECD. BY LOCAL REG.: July 6, 1959
26. REGISTRAR'S SIGNATURE: Mrs R E Palmer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Leonard B. Jmu

Licensed Embalmer No. 250

P. O. Address Buffalo

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