Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-021009
STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 672 A

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) BURGE HOSPITAL — Length of stay in lb ARPROX 2 hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY GREENE
c. CITY OR TOWN STRAFFORD — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Route # 3 — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First RUTHIE Middle MAE Last PEAK

4. DATE OF DEATH Month June Day 19, Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH June 19, 1959
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 5 Min. 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (City and state or country) Springfield, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Homer Peak
13b. MOTHER'S MAIDEN NAME Elca Campbell
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) no
16. SOCIAL SECURITY NO. no
17. INFORMANT Address Mr. Homer Peak, Strafford, Mo, Route 3

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) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH 6 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Premature Birth
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 6-19-59, to 6-19-59 and last saw her/him alive on 6-19-59
Death occurred at 5:45 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature], Mo
22b. ADDRESS Prof. Bldg. Spfld, Missouri
22c. DATE SIGNED 6-25-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE June 20, 1959
23c. NAME OF CEMETERY OR CREMATORY Bassville Cemetery
23d. LOCATION (City, town, or county) (State) Greene County, Missouri

24. ~~FUNERAL DIRECTOR~~ (father) ADDRESS R-3, Strafford Missouri Homer E Peak
25. DATE RECD. BY LOCAL REG. 6-29-59
26. REGISTRAR'S SIGNATURE Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

Not Embalmed

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.