pt. Health, .., & Welfare S. Public lth Service

. S. 300 v. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-022136
STATE FILE NUMBER

JUL 13 1959 Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 109

1. PLACE OF DEATH
a. COUNTY: MACON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): MACON — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): SAMARITAN HOSP — Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: MACON
c. CITY OR TOWN: MACON — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): NONE INFANT — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: KAREN Middle: SUE Last: ALEXANDER

4. DATE OF DEATH Month: JUN Day: 28 Year: 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 27 1959
9. AGE (In years last birthday): — IF UNDER 1 YEAR Months: Days: — IF UNDER 24 HRS Hours: 19 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 of country): MACON MO
12. CITIZEN OF WHAT COUNTRY?: US

13a. FATHER'S NAME: VERN ALEXANDER
13b. MOTHER'S MAIDEN NAME: DORIS ELAIN WOOD
14. NAME OF HUSBAND OR WIFE: —

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: MARY WOOD Address: SHELBYVILLE MO

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): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 19 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (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)
776X

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 June 27, to June 28 and last saw her alive on June 28
Death occurred at 9:02 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): James E. Campbell MD
22b. ADDRESS: Macon Mo
22c. DATE SIGNED: 7/1/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 6-29-59
23c. NAME OF CEMETERY OR CREMATORY: IOOF CEMETERY
23d. LOCATION (City, town, or county) (State): SHELBYVILLE MO

24. FUNERAL DIRECTOR: GREENING Address: SHELBYVILLE MO
25. DATE RECD. BY LOCAL REG.: 7/1/59
26. REGISTRAR'S SIGNATURE: Ruth McNeely

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

County File No. ....

Date Filed 7-10-59

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 [signature]

Licensed Embalmer No. 4625

P. O. Address Clarence M[illegible]

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.