

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024132

FILED VS AUG 4 1959 38

3006

331

STATE FILE NUMBER

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> COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		c. CITY OR TOWN <b>New Franklin</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Parkade Addition</b>		d. STREET ADDRESS (If outside, give location) <b>-----</b>	
Length of stay in 1b <b>----</b>		Inside Limits <b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>MARVIS</b> Middle <b>MARVIN</b> Last <b>Humphrey</b>			4. DATE OF DEATH <b>July 23 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-1924</b>	9. AGE (last birthday) <b>35</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and state or country) <b>Mokane, Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>			13a. FATHER'S NAME <b>Emir Scott Humphrey</b>	
13b. MOTHER'S MAIDEN NAME <b>Ethel Mae Clingman</b>			14. NAME OF HUSBAND OR WIFE <b>Nellie Fern Humphrey</b>	
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. <b>-----</b>	
17. INFORMANT <b>Tom Markland, New Franklin, Mo</b>			Address <b>-----</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
IMMEDIATE CAUSE (a) <b>Suffocation (Asphyxia)</b>			
DUE TO (b) <b>-----</b>			
DUE TO (c) <b>-----</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Deceased was working on a ditch approximately 10 feet deep when walls of ditch caved in covering him with a large quantity of earth.</b>	
20c. TIME OF INJURY <b>3:15 p.m.</b> Hour <b>7</b> Month <b>23</b> Day <b>59</b> Year	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		
20e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <b>Columbia</b>	COUNTY <b>Boone</b>	STATE <b>Missouri</b>

21. I attended the deceased from <b>Coroner's Case</b> and last saw him alive on <b>-----</b>	
Death occurred at <b>approx 3:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Vincent P Perme, M.D. Coroner</b>	22b. ADDRESS <b>Univ. of Mo. Medical Center</b>
22c. DATE SIGNED <b>July 23, 1959</b>	(State) <b>-----</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-25-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant</b>	23d. LOCATION (City, town, or county) <b>New Franklin, Mo.</b>
---	----------------------------	--	--

24. FUNERAL DIRECTOR <b>Tom Markland, New Franklin, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>July 25 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>
---	--	--

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 4 1959

AUG 12 1959

**STATEMENT BY LICENSED EMBALMER**

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

by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Lynna W. Spunk*

Licensed Embalmer No. 4013

P. O. Address Columbia

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