

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 13 1959

59-026178

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 138

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Crawford</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rolla</u>		Length of stay in 1b <u>6 Hrs.</u>		c. CITY OR TOWN <u>Bourbon</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Phelps Co. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>STAR ROUTE</u>		
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Lee</u> Last <u>West</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-1947</u>	9. AGE (last birthday) <u>12</u>	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) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Bourbon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Oral West</u>			13b. MOTHER'S MAIDEN NAME <u>Leona Kelly</u>			14. NAME OF HUSBAND OR WIFE <u>Star Rt. Bourbon, Mo</u>	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Oral West</u>		Address <u>Star Rt. Bourbon, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound rt. chest</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
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)						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 type="checkbox"/> NO <input checked="" 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 this 16.) <u>Brother playing with gun shot him</u>					
20c. TIME OF INJURY <u>9:15 a.m.</u>	Hour <u>9:15</u> Month, Day, Year <u>Aug 3, 1959</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>Leasburg</u>		COUNTY <u>Crawford</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>3 Aug 59</u> to <u>3 Aug 59</u> and last saw her <u>alive</u> on <u>3 Aug 59</u>				Death occurred at <u>3:15</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ronald Van Arsdell M.D.</u>			22b. ADDRESS <u>Bourbon, Mo.</u>			22c. DATE SIGNED <u>4 Aug 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-5-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cross Roads</u>		23d. LOCATION (City, town, or county) <u>Leasburg</u>		STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Norman @ Hoener</u>			ADDRESS <u>Cuba, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 4, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>		

DOCUMENT

MEDICAL CERTIFICATION

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Norman C. Haer

Licensed Embalmer No. 467

P. O. Address Cuba, N

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.