

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028146

FILED VS SEP 8 1959 38

Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 414

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b	c. CITY OR TOWN <u>Versailles</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U of Mo Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>GAY</u> Last <u>Lee</u>			4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</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>8-24-59</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Versailles, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Nelson Lee.</u>		13b. MOTHER'S MAIDEN NAME <u>Daylone Coffman</u>		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) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Medical Center Records</u> Address			
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>Acute cardiac decompensation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Congenital heart disease</u>				<u>8 days</u>	
	DUE TO (c) <u>(Truncus arteriosus, Cor trilobulare)</u>					
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input 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.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>9-1-59</u> to <u>9-1-59</u> and last saw her/him alive on <u>9-1-59</u> Death occurred at <u>130 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>James K. Mann, M.D.</u> (Degree or title)			22b. ADDRESS <u>Columbia, Missouri</u>		22c. DATE SIGNED <u>9-1-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 3, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glensted Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Glensted Missouri</u>		
24. FUNERAL DIRECTOR <u>Sciencel Funeral Home Versailles, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Sept 3 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</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 James R. Scramie

Licensed Embalmer No. 4880

P. O. Address Verona, N.J.

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.