

REGISTRATION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59-028167

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 378

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Mo.</u> Length of stay in 1b <u>11 hrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Medical Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u> c. CITY OR TOWN <u>Columbia,</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Rt. # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Richard</u> Last <u>Street</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-02</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming & Motel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel Owner</u>		11. BIRTHPLACE (City and state or country) <u>Maries County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>Richard Street</u>		13b. MOTHER'S MAIDEN NAME <u>Mary West</u>		14. NAME OF HUSBAND OR WIFE <u>Frances L. Spickard</u>			
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>491-24-3412</u>	17. INFORMANT Address <u>Hospital Records</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>Hemorrhage into the bowel</u> DUE TO (b) <u>extensive recurrent of carcinoma in the bowel.</u> DUE TO (c) <u>carcinoma of the recto sigmoid colon</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) <u>Jaundice; recurrent carcinoma</u>					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 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 _____ a.m. _____ p.m. Month, Day, Year _____		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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE		
21. I attended the deceased from <u>17 Aug AM</u> to <u>18 Aug pm</u> and last saw her/him alive on _____ Death occurred at <u>8:40 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. P. Ellis, M.D.</u>			22b. ADDRESS <u>U. of Mo. Med. Center</u>		22c. DATE SIGNED <u>18 Aug 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Parson Funeral Service, Columbia, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Aug 19 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. P. E. Palmer</u>		

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 1 1958

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 J. W. Phillips

Licensed Embalmer No. 4897
P. O. Address Coleman, Miss.

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.