

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 13 1959

59-031466

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 471

IDED

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|------------------------------------|--|
| 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>SALINA</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | | Length of stay in lb <u>26 days</u> | | c. CITY OR TOWN <u>MARSHALL</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>University 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 2</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>LUTHER</u> Middle <u>—</u> Last <u>RODDEN</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>4</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>3-31-1900</u> | 9. AGE (last birthday) <u>59</u> | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Laclede Co Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>HENRY Rodden</u> | | | 13b. MOTHER'S MAIDEN NAME <u>SARA h Holden</u> | | | 14. NAME OF HUSBAND OR WIFE <u>FLORENCE Rodden</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>493-14-0149</u> | | 17. INFORMANT Address <u>University of Missouri Medical Center</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>Aspiration Pneumonia</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>UREMIA</u> | | | | | | | 6 months | | |
| DUE TO (c) <u>CHRONIC RENAL FAILURE</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Septisemia</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 <u>—</u> a.m. <u>—</u> Month, Day, Year <u>—</u> | | | | | | | | | |
| 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>9-9-59</u> to <u>10-4-59</u> and last saw her/him alive on <u>10-4-59</u> Death occurred at <u>1:10 Am</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Michael J. Anziani, M.D.</u> | | | | 22b. ADDRESS <u>U. of Mo. Med Center</u> | | | | 22c. DATE SIGNED <u>10/4/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u> | | 23b. DATE <u>Oct 4, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) <u>Marshall Mo</u> | | (State) | | |
| 24. FUNERAL DIRECTOR <u>Parker Funeral Service Columbia, Mo</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>Oct 4 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 Donald L. Roberts

Licensed Embalmer No. 4722

P. O. Address Columbia, S.C.

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.