

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032788

FILED VS SEP 22 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 440

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin</u>		Length of stay in lb <u>one day</u>		c. CITY OR TOWN <u>rt 1, Seneca</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>Freeman Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3 mi. so of Seneca</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarissa Dawn Whitehead</u>				4. DATE OF DEATH Month Day Year <u>Sept. 5, 1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wht</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>9/4/59</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months Days <u>1</u>		IF UNDER 24 HR Hours Min. <u>1</u>		
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 -----		11. BIRTHPLACE (City and state or country) <u>Joplin, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Clarence A. Whitehead</u>			13b. MOTHER'S MAIDEN NAME <u>Wanda Anderson</u>			14. NAME OF HUSBAND OR WIFE <u>Mo.</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>None</u>		17. INFORMANT <u>Clarence Whitehead, rt 1, Seneca Mo.</u>				
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	
IMMEDIATE CAUSE (a) <u>Atelectasis</u>								<u>at birth</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prematurity</u>								<u>5 Weeks</u>	
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 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 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>9-4-59 @ 11:52am</u> to <u>9-5-59 @ 10:pm</u> and last saw her alive on <u>9-5-59</u> Death occurred at <u>10:00 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Alice H. Wilson MD</u>				22b. ADDRESS <u>1923 Sergeant Avenue</u>				22c. DATE SIGNED <u>9-5-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/7/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cem. Swars Prairie Baptist</u>		23d. LOCATION (City, town, or county) (State) <u>Newton Co., Missouri</u>				
24. FUNERAL DIRECTOR <u>W E Bledsoe</u>			ADDRESS <u>Seneca Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-16-1959</u>		26. REGISTRAR'S SIGNATURE <u>Dove Merriam</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 W. E. Bell

Licensed Embalmer No. 2174

P. O. Address Seneca

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.