

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039653

FILED VS. NOV 23 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1044A

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b		c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1880 N Marion			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1880 N Marion			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last GODDARD				4. DATE OF DEATH October 3, 1959 on or about Day Year				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Oct 3, 1959	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (City and state or country) Springfield, Mo		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Wanda Marie Longard		14. NAME OF HUSBAND OR WIFE none				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no			16. SOCIAL SECURITY NO. none	17. INFORMANT Court records and Newspapers 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) exsanguination							INTERVAL BETWEEN ONSET AND DEATH ?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) due to severance of umbilical cord						
		DUE TO (c) (verdict of Coroner's Inquest Jury 11/2/59)						
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 checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Coroner's Inquest Jury verdict was that the mother Mrs. Wanda Goddard severed the				
20c. TIME OF INJURY Hour a.m. p.m. about Oct. 3, 1959	Month, Day, Year			20b. umbilical cord soon after birth then caused the body to be burned in open fire nearby.				
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.) at home		20f. CITY, TOWN, OR LOCATION Springfield, Greene, Missouri		COUNTY STATE		
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at undecided _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>[Signature]</i> (Degree or title) Greene County Coroner				22b. ADDRESS Springfield, Missouri		22c. DATE SIGNED 11/17/59		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
Held in Laboratory at Baptist Hospital				25. DATE RECD. BY LOCAL REG. 11-20-59		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
24. FUNERAL DIRECTOR ADDRESS								

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

Not embalmed

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.