

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-039847

STATE FILE NUMBER

FILED VS NOV 23 1959

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 156

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp</u>		Length of stay in 1b <u>6 hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>0</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Aubrey</u> Middle <u>Neal</u> Last <u>Luna</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>M.</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>11-4-1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>←</u>	9. AGE (In years last birthday) <u>6</u> IF UNDER 1 YEAR: Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. <u>6</u>
11. BIRTHPLACE (City and state or country) <u>West Plains Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Bernard Luna</u>		13b. MOTHER'S MAIDEN NAME <u>Handa D. Green</u>	
14. NAME OF HUSBAND OR WIFE <u>←</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. <u>←</u>		17. INFORMANT <u>Bernard Luna</u> Address <u>West Plains Mo</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>Pulmonary atelectasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Prematurity (7 mos)</u> DUE TO (c) <u>←</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
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.) <u>7625</u>		20c. TIME OF INJURY Hour <u>9¹⁵</u> a.m. Month, Day, Year p.m.	
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 <u>West Plains Mo</u>		COUNTY STATE	
21. I attended the deceased from <u>9¹⁵ am</u> to <u>3¹⁵ pm</u> and last saw her/him alive on <u>11-4-1959</u> Death occurred at <u>3:15 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M L Fowler MD</u> (Degree or title)		22b. ADDRESS <u>West Plains Mo</u>	
22c. DATE SIGNED <u>11/13/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>11-5-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ball Cemetery, Alora, Mo.</u>	
23d. LOCATION (City, town, or county) <u>Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Reberhaus</u> Address <u>West Plains Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-59</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed 3432 - R. D. Robertson

Licensed Embalmer No. 3432

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.