

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 043318

FILED VS JAN - 4 1960

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 645

UNRECORDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Boone</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>Columbia</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U.M.M.C</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 type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>Robert</u>	Middle <u>Eugene</u>	Last <u>Cross</u>	Month <u>Dec.</u>	Day <u>28</u>	Year <u>1959</u>	

5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-59</u>	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months <u>2</u>	Days <u>2</u>	Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	---

13a. FATHER'S NAME <u>Eddie Griffin Cross</u>	13b. MOTHER'S MAIDEN NAME <u>Helen Darby Stapleton</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 war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>Hospital chart</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>pulmonary insufficiency</u>		<u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Prematurity 24-28 wks</u>	<u>48 hrs.</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)		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> Month, Day, Year <u></u>
a.m. <u></u>	p.m. <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 12-26-59 to 12-28-59 and last saw her him alive on 12-28-59
 Death occurred at 1:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James K. Mann, M.D.</u>	22b. ADDRESS <u>University Hospital Columbia, Mo.</u>	22c. DATE SIGNED <u>12-28-59</u>
---	---	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/29/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri State Anatomical Board, Columbia, Mo.</u>	23d. LOCATION (City, town, or county) (State)
--	---------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>M.D. Overholser, M.D. M.D. Overholser</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 30 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

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 me
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.