

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 9 5 7

FILED VS. DEC 28 1959 8

Primary Registration District No. 2000

Registrar's No. 1347B

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Polk</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>5 da</u>		c. CITY OR TOWN <u>Rural-Maior</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Peter</u> Last <u>Stanch</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1959</u>				
5. SEX <u>Male</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>Nov. 28-1959</u>	9. AGE (last birthday) <u>14</u>	IF UNDER 1 YEAR Months <u>14</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>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Charles W. Stanch</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Gasche</u>		14. NAME OF HUSBAND OR WIFE <u>Infant</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>Mo</u>		17. INFORMANT <u>Charles W. Stanch - Pol. 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>Pneumonia right lung</u>							Since birth	
DUE TO (b) <u>Congenital tracheo-esophageal fistula, post operative status</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 checked="" type="checkbox"/> NO <input 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> p.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>12/1/59</u> to <u>12/10/59</u> and last saw her him alive on <u>12/10/59</u> Death occurred at <u>9:45 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>John W. Roth, MD</u> (Degree or title)			22b. ADDRESS <u>604 Med. Arts Bldg. Springfield, Mo.</u>		22c. DATE SIGNED <u>12/19/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Dec. 12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Wenceslaus</u>		23d. LOCATION (City, town, or county) (State) <u>Polk Co. Mo.</u>				
24. FUNERAL DIRECTOR <u>Pitts F. H. Polivan, Mr.</u>		ADDRESS <u></u>		25. DATE RECD. BY LOCAL REG. <u>12-21-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr Polk

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 *L. Pauline Gorman*

Licensed Embalmer No. 3177
P. O. Address Springfield

* 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.