

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000194

FILED VS FEB 1 1960

38

Registration District No. 3006

Registrar's No. 39

STATE FILE NUMBER

| | | | | | | | | | |
|--|--|---|--|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Boone | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY New Madrid | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Columbia | | Length of stay in 1b 31 days | | c. CITY OR TOWN Marston | | 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. of Mo. Medical Center | | | 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 Flossie Middle Howell Last Jefferies | | | | 4. DATE OF DEATH Month Jan. Day 22 Year 1960 | | | | | |
| 5. SEX F | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 5-9-03 | 9. AGE (last birthday) 56 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home. | | 11. BIRTHPLACE (City and state or country) State of Arkansas | | 12. CITIZEN OF WHAT COUNTRY USA. | | |
| 13a. FATHER'S NAME Van Howell | | | 13b. MOTHER'S MAIDEN NAME Margie Sheppard | | | 14. NAME OF HUSBAND OR WIFE Deceased | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Hospital Chart | | | | |
| 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) Myocardial infarction | | | | | | | 4 hours | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease | | | | | | | unknown | | |
| DUE TO (c) Diabetes mellitus | | | | | | | Unknown. | | |
| 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 checked="" 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 December 22, 1959 to January 22, 1960 and last saw her alive on January 22, 1960 Death occurred at 9:50 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree, or title) Dale B. Sprinkle, M.D. | | | | 22b. ADDRESS University Hospital, Columbia, Mo. | | | 22c. DATE SIGNED Jan 23, 1960 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/23/60 | 23c. NAME OF CEMETERY OR CREMATORY Portageville Cemetery | | 23d. LOCATION (City, town, or county) (State) Portageville, Mo. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Lyman Sprinkle Columbia, Mo. | | | | 25. DATE RECD. BY LOCAL REG. Jan 23 1960 | | 26. REGISTRAR'S SIGNATURE Mrs R E Palmer | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 11 1960

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

George A. ...

Licensed Embalmer No. *4425*

P. O. Address *Columbe*

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.