

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005131

FILED VS MAR 14 1960

38

3006

153

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

EMENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in lb <u>1 month</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo Med Cen</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>WARREN</u> c. CITY OR TOWN <u>MARTHASVILLE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Darryl</u> Middle <u>Joseph</u> Last <u>Herbst</u>			4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>60</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>2-1-60</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Washington, Missouri</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Andrew Herbst</u>		13b. MOTHER'S MAIDEN NAME <u>MARY FELDMANN</u>			
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Hospital chart</u>		17. ADDRESS <u>Columbia, Missouri</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>Acute cardiac failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congenital heart disease</u> DUE TO (c) <u>(Aortic atresia)</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 _____ a.m. _____ p.m.		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		20g. COUNTY		20h. STATE			
21. I attended the deceased from <u>2-11-60</u> to <u>3-11-60</u> and last saw her <u>3-11-60</u> alive on Death occurred at <u>12:01 P</u> 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 of Missouri Medical Center</u>		22c. DATE SIGNED <u>3-11-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/12/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marthaville, Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Marthaville, Missouri</u>		
24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u>			25. DATE RECD. BY LOCAL REG. <u>Mar 11 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R & 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George A. Kamm

Licensed Embalmer No. 4425

P. O. Address Columbia

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.