

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005830

FILED VS FEB 29 1960/28

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 224

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Green</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>DOUGLAS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>2 WEEKS</u>	c. CITY OR TOWN <u>VANZANT</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SPRINGFIELD BAPTIST HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ROUTE #1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MURPHY</u> Middle <u>WAYNE</u> Last <u>COLLINS</u>			4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>21</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> In Part <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/1960</u>	9. AGE (last birthday) <u>23</u>	IF UNDER 1 YEAR Months _____ Days <u>23</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		11. BIRTHPLACE (City and state or country) <u>CABOOL, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>DOYNE WAYNE COLLINS</u>		13b. MOTHER'S MAIDEN NAME <u>VETA FAY ELLIOTT</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) <u>NO</u>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>DOYNE WAYNE COLLINS - VANZANT, MISSOURI</u>		Address			
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>Uremia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 wks</u>
DUE TO (b) <u>Dehydration and Shock</u>					<u>2 wks</u>
DUE TO (c) <u>Congenital Adrenal Hyperplasia</u>					<u>From birth</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pseudohermaphroditism, Female</u>					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 _____ Month, Day, Year _____ 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		COUNTY	STATE
21. I attended the deceased from <u>2-9-60</u> to <u>2-21-60</u> and last saw her/him alive on <u>2-21-60</u> Death occurred at <u>3:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Donald Overeul MD</u> (Deceased or title)			22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>2-24-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2/23/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VANZANT CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>DOUGLAS COUNTY, MISSOURI</u>	
24. FUNERAL DIRECTOR <u>BARBER FUNERAL HOME - MTN. GROVE, MISSOURI</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-25-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

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 Stapp

Licensed Embalmer No. 3161

P. O. Address Mt. Grove, Pa.

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.