URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS FEB 16 1960

-60-007656

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 12

ENDED

1. PLACE OF DEATH
a. COUNTY Pulaski
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ft Leonard Wood, Mo
Length of stay in 1b: 3 hrs, 7 min
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pulaski
c. CITY OR TOWN Ft Leonard Wood
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) US Army Hospital
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Johnny Middle Ray Last Farmer
4. DATE OF DEATH: Month Jan Day 31 Year 60
5. SEX: Male
6. COLOR OR RACE: Cau
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1-31-60
9. AGE (last birthday) IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours 3 Min. 7
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): Ft Leonard Wood, Mo
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Charles Farmer
13b. MOTHER'S MAIDEN NAME: Gertrude Gimenhout
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: Charles Farmer Address: Ft Leonard Wood, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory insufficiency
INTERVAL BETWEEN ONSET AND DEATH: 3 hrs, 7 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan 31, 1960, to Jan 31, 1960 and last saw him alive on Jan 31, 1960
Death occurred at 12:37 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Nahman H. Greenberg NAHMAN H. GREENBERG, Capt, MC
22b. ADDRESS: US Army Hospital, Ft Leonard Wood
22c. DATE SIGNED: 2-1-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb 3 1960
23c. NAME OF CEMETERY OR CREMATORY: Post Cemetery
23d. LOCATION (City, town, or county) (State): Ft Leonard Wood Missouri

24. FUNERAL DIRECTOR: B. Hedges
ADDRESS: HEDGES FUNERAL HOMES INC CROCKER MO
25. DATE RECD. BY LOCAL REG.: 2-3-60
26. REGISTRAR'S SIGNATURE: Eula Mae Anderson

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4896

P.O. Address Waynesville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.