

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009880

FILED VS APR 4 1960

38

Registration District No. Primary Registration District No. 3006 Registrar's No. 203

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Columbia</u>		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>Boone County</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>402 Conley Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Robert</u> Last <u>Henley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/24/60</u>	9. AGE (last birthday) <u>—</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HR Hours <u>1</u> Min. <u>1</u>		
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>Columbia Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Paul Ray Henley</u>			13b. MOTHER'S MAIDEN NAME <u>Judith Helen Kopp</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 Address <u>Paul Henley - 402 Conley Columbia</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>marked bilateral atelectasis - lungs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hyaline membrane disease</u>		DUE TO (c) <u>Premature birth</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 checked="" 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> 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>birth 3-24-60</u> to <u>3-25-60</u> and last saw ^{her} him alive on <u>3-25-60</u> Death occurred at <u>12 30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Ray B Lavin M.D.</u> (Degree or title)				22b. ADDRESS <u>Columbia, Mo</u>				22c. DATE SIGNED <u>3-27-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>3-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Boone County Hospital</u>		23d. LOCATION (City, town, or county) <u>Columbia</u>		23e. (State) <u>Missouri</u>		
24. FUNERAL DIRECTOR <u>Loraine E. Schultz M.D.</u> ADDRESS <u>Boone County Hosp Columbia, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>April 1 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.