

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 28 1960

60-009912

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>16 days.</u>		c. CITY OR TOWN <u>New Madrid</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>UNIVERSITY OF MO. MEDICAL CENTER</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>Tennessee Alley</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Robinson Walker</u>				4. DATE OF DEATH Month Day Year <u>3 - 23 - 60</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-22</u>	9. AGE (last birthday) <u>38</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>New Madrid</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>OSCAR Robinson</u>			13b. MOTHER'S MAIDEN NAME <u>MATTIE BERRY</u>			14. NAME OF HUSBAND OR WIFE <u>deceased</u>		
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 Address <u>UNIVERSITY OF MO. MEDICAL RECORDS</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>UREMIA + CARDIAC FAILURE</u> DUE TO (b) <u>chronic glomerulonephritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Dec 1959</u> To <u>March 23, 1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>hypertensive cardiovascular disease</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 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 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 <u>3-7-60</u> to <u>3-23-60</u> and last saw her ^{her} _{him} live on <u>3-22-60</u> Death occurred at <u>6:22</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22b. SIGNATURE (Degree or title) <u>Michael J. Anigian MD</u>				22b. ADDRESS <u>U. of Missouri Medical Center</u>		22c. DATE SIGNED <u>3/23/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3/25/1960</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>New Madrid, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Lyman Sprinkle Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Mar 25 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmeter</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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 443
P. O. Address Columbia

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