

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014170

FILED VS APR 25 1960

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Primary Registration District No. 3006

Registrar's No. 240

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Boone</u>	a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>		
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>Columbia</u>	Length of stay in 1b <u>14 day</u>	c. CITY OR TOWN <u>Webb City</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>Missouri University Medical Center</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1 - Box 337</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>Pearl</u>	Middle <u>Sargent</u>	Last <u>Bailey</u>	Month <u>April</u>	Day <u>18</u> Year <u>1960</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-91</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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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	11. BIRTHPLACE (City and state or country) <u>Huntington, Arkansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Sargent</u>	13b. MOTHER'S MAIDEN NAME <u>Hanna</u>	14. NAME OF HUSBAND OR WIFE <u>Archie Bailey</u>
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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>M.U. Medical Records - Missouri</u>	Address <u>Columbia</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>ACUTE MYELOCYTIC LEUKEMIA</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
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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
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21. I attended the deceased from 4-4-60 to DEATH and last saw her alive on 4-18-60
 Death occurred at 10 53 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree & title) <u>Dale B. Sparks M.D.</u>	22b. ADDRESS <u>University Hospital</u>	22c. DATE SIGNED <u>4-19-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>JOPLIN MISSOURI</u>
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24. FUNERAL DIRECTOR <u>PARKERS FUNERAL SERVICE</u>	ADDRESS <u>COLUMBIA MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>April 19, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 26 1963

STATEMENT BY LICENSED EMBALMER

MAY 13 1960

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 Donald L. Roberts

Licensed Embalmer No. 4722
P. O. Address Columbia, Mo.

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.