

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 25 1960 38

-60-014194

Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 235

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Boone			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Length of stay in 1b 5 hrs		c. CITY OR TOWN Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Boone County Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 305 Sanford			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roberta Middle Marie Last McGowan				4. DATE OF DEATH Month 4 Day 18 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/19/45	9. AGE (last birthday) 14	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress			10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (City and state or country) Peoria, Illinois		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Robert G. McGowan			13b. MOTHER'S MAIDEN NAME Margie Summers			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) no			16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Maxine Starke Columbia, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive head injuries and transection of spinal cord Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) trauma DUE TO (c) Motor vehicle accident						INTERVAL BETWEEN ONSET AND DEATH 4 hrs " "	
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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Deceased was passenger in a car				
20c. TIME OF INJURY 1015 p.m.	Hour _____ Month, Day, Year April 17, 1960	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> involved in two car accident					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street			20f. CITY, TOWN, OR LOCATION Missouri Turnpike		COUNTY Boone		STATE Missouri
21. I attended the deceased from Coroner's Case last saw him alive on _____ Death occurred at approx 2:30 on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Vincent P Perera M.D. Coroner				22b. ADDRESS Univ. of Mo. Medical Center			22c. DATE SIGNED 18 Apr. 60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/20/1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) Columbia, Mo.			
24. FUNERAL DIRECTOR Lyman Sprinkle Columbia, Mo.				25. DATE RECD. BY LOCAL REG. April 18 1960		26. REGISTRAR'S SIGNATURE Mrs R.E. Palmer	

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 _____

Licensed Embalmer No. 4425

P. O. Address Columbiana

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.