

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018332

FILED JUN 6 1960 38 Primary Registration District No. 3006 Registrar's No. 314

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY BOONE COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY GREENE					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COLUMBIA		Length of stay in 1b 23 days		c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR THE ELLIS FISCHEL STATE INSTITUTION CANCER HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2121 NORTH WELLS		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SARAH Middle ANN Last ERICKSON			4. DATE OF DEATH Month MAY Day 28 Year 60						
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-24-73	9. AGE (last birthday) 86	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) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) NANTUCKET - PENNA.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME JOHN MAPSTON			13b. MOTHER'S MAIDEN NAME MARY LOCKE			14. NAME OF HUSBAND OR WIFE Deceased			
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. NONE		17. INFORMANT Address HOSPITAL RECORDS ELLIS FISCHEL HOSPITAL HIGHWAY 40 GARTH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLISM.							INTERVAL BETWEEN ONSET AND DEATH 12 HOURS		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) AURICULAR FIBRILLATION									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CARCINOMA OVARIES, EXTENSIVE - INTESTINAL OBSTRUCTION					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 type="checkbox"/> NO <input checked="" 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 MAY 4 - 60 to 5-28-60 and last saw her/him alive on 5-28-60 Death occurred at ELLIS FISCHEL HOSPITAL on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Ralph J. Gray MD (Degree or title)				22b. ADDRESS Ellis Fischel Hospital			22c. DATE SIGNED 5/28/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-31-1960		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Springfield Mo.			
24. FUNERAL DIRECTOR Rex Rainey, Springfield, Mo. ADDRESS				25. DATE RECD. BY LOCAL REG. May 31, 1960		26. REGISTRAR'S SIGNATURE Mrs. R.E. Palmer			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

REC'D 27 1960

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. 363

P. O. Address _____

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