

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-022333**

**FILED VS JUN 20 1960**

38

Primary Registration District No. 3006 Registrar's No. 248

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Boone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Webster</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>2 days</b>	c. CITY OR TOWN <b>Elkland</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>W. of M.M.C.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 2</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GREGORY</b> Middle <b>AEROY</b> Last <b>West</b>			4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/8/60</b>	9. AGE (last birthday) <b>N.B.</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Columbia, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Carl West</b>		13b. MOTHER'S MAIDEN NAME <b>Freda Vance</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>CARL WEST, ELKLAND MO R2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO (b) <b>Erythroblastosis Fetalis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b> <b>2 days</b>	
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 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 <b>6-8-60</b> to <b>6-10-60</b> and last saw <sup>her</sup> him alive on <b>6-10-60</b> Death occurred at <b>3:00 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>James K. Mann, MD</b>			22b. ADDRESS <b>University Hospital Columbia, Mo.</b>		22c. DATE SIGNED <b>6-10-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>6-10-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WEAICH</b>	23d. LOCATION (City, town, or county) (State) <b>WEBSTER CO MO</b>			
24. FUNERAL DIRECTOR <b>BARBER-EDWARDS, MARSHFIELD</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>June 14 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>		

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 Not Embalmed.

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.