

# DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023739

FILED VS **1-1-1966** 184 Primary Registration District No. 3038 Registrar's No. 83

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield, Mo</u> Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pershing Memorial Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN <u>Columbus</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>390 Oakland Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lois</u> Middle <u>Jeanne</u> Last <u>Haldeman</u>			<b>4. DATE OF DEATH</b> Month <u>7</u> - Day <u>4</u> - Year <u>60</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>w</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-10-1930</u>	<b>9. AGE (last birthday)</b> <u>30</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HR</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mathematician</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>North American Aviatn</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Lancaster Ohio</u>		<b>12. CITIZEN OF WHAT COUNTRY</b>	
<b>13a. FATHER'S NAME</b> <u>Rodric</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Marion Pfeiffer</u>		<b>14. NAME OF HUSBAND OR WIFE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>974 28-2672</u>		<b>17. INFORMANT</b> <u>Paula Haldeman</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock-</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Blood loss w/ soft tissue damage.</u> DUE TO (c) <u>Automobile Accident.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs -</u> <u>18 hrs.</u>		
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 checked="" type="checkbox"/> N: <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>Auto Accident H. way 36.</u>				
<b>20c. TIME OF INJURY</b> Hour <u>2:10</u> Month, Day, Year <u>7 3 60</u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hway 36 4.5.</u>			
<b>20f. CITY, TOWN, OR LOCATION</b> <u>3 mi west Brookfield</u>		<b>COUNTY</b> <u>MO.</u>		<b>STATE</b>			
<b>21. I attended the deceased from</b> <u>7-3-60</u> to <u>7-4-60</u> and last saw her alive on <u>7-4-60</u> . Death occurred at <u>11:06</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>K.W. Bateman Sr.</u>			<b>22b. ADDRESS</b> <u>3147 1/2 Main Brookfield Mo</u>		<b>22c. DATE SIGNED</b> <u>7/4/60.</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE</b> <u>July 4, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Rose Cemetery</u>		<b>23d. LOCATION (City, town, or county)</b> <u>Lancaster, Ohio</u> (State)		
<b>24. FUNERAL DIRECTOR</b> <u>Wright Funeral Home, Brookfield, Mo.</u> ADDRESS			<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-4-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Katharine Johnson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 12 1960  
JUL 25 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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo

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.