

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025828

FILED VS JUL 18 1960

38

Registration District No. 3006 Registrar's No. 389

STATE FILE NUMBER

DED

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>Macan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>10 months</b>		c. CITY OR TOWN <b>New Cambria</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>University of Missouri Medical Center</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 type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Steven</b> Middle <b>Gail</b> Last <b>Pate</b>				4. DATE OF DEATH Month <b>7</b> Day <b>8</b> Year <b>60</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>4-12-58</b>	9. AGE (last birthday) <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HR Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>New Cambria, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George Pate</b>			13b. MOTHER'S MAIDEN NAME <b>Nettie Shatto</b>			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)		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Medical Records University of Missouri</b> Address <b>Medical Center University of Missouri</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>ANOTIA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 mos</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Congenital Heart Disease</b>					
		DUE TO (c) <b>COMMON ATRIO-VENTRICULAR CANAL</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>						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 <b>4:10 P</b> Month, Day, Year <b>9/16/59</b>		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 <b>Columbia</b>		COUNTY <b>Boone</b>		STATE <b>Missouri</b>	
21. I attended the deceased from <b>9/16/59</b> to <b>7/8/60</b> and last saw her/him alive on <b>7/8/60</b> Death occurred at <b>4:10 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Ray August Westerland MD</b>				22b. ADDRESS <b>102 Stadium Rd, Columbia</b>		22c. DATE SIGNED <b>7/8/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>7-9-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Now Cambria</b>		23d. LOCATION (City, town, or county) (State) <b>MO</b>		
24. FUNERAL DIRECTOR <b>Parke Funeral Service</b>		ADDRESS <b>Columbia</b>		25. DATE RECD. BY LOCAL REG. <b>July 9 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

*Donald L Roberts*

Licensed Embalmer No.

*4722*

P. O. Address

*Columbia*

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.