

# FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 30 1960

-60-031554  
STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 293

DEED

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SALINE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>SEDALIA</u>		Length of stay in 1b <u>2 DAYS</u>	c. CITY OR TOWN <u>SWEET SPRING</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BOTHWELL HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>102 WILLA ST</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARK</u> Middle <u>ALLEN</u> Last <u>PAUL</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 21, 1960</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>SEDALIA MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	

13a. FATHER'S NAME <u>MILTON WAYNE PAUL</u>		13b. MOTHER'S MAIDEN NAME <u>JOYCE ANN STIEGEMEYER</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MILTON W. PAUL SWEET SPRING, MO</u> Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline Membrane Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
DUE TO (b) <u>Fracture Skull.</u>			
DUE TO (c) _____			
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 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 Aug 21 to Aug 22 and last saw him alive on Aug 22, 1960  
Death occurred at 3:35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul K. ...</u>	22b. ADDRESS <u>Sweet Springs Mo</u>	22c. DATE SIGNED <u>8-23-60</u>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8/23/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CONCEPTIA MO</u>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <u>E. S. James</u>	ADDRESS <u>Concordia Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8/23/1960</u>	26. REGISTRAR'S SIGNATURE <u>Lancee Shelby</u>
--	--------------------------------	--	---

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 Mr \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. S. James  
Licensed Embalmer No. 2058  
P. O. Address Concordia

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.