RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-035754
STATE FILE NUMBER

LED VS SEP 21 1960 Registration District No. 290 Primary Registration District No. _____ Registrar's No. 126

DED

1. PLACE OF DEATH
a. COUNTY: Pulaski
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Ft. Leonard Wood
Length of stay in 1b: 9 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: US Army Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Pulaski
c. CITY OR TOWN: Ft. Leonard Wood
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): US Army Hospital
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Nancy Middle: Bess Last: Aumann

4. DATE OF DEATH: Month: Sep Day: 3 Year: 60

5. SEX: Female

6. COLOR OR RACE: Cau

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-25-60

9. AGE (last birthday)

IF UNDER 1 YEAR: Months: Days: 9
IF UNDER 24 HR: Hours: Min.

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): Ft. Leonard Wood. Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Robert W. Aumann

13b. MOTHER'S MAIDEN NAME: Martha Banghart

14. NAME OF HUSBAND OR WIFE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT Address: Robert W. Aumann, Ft. Leonard Wood, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory arrest	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Meningitis	5 days
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 August 25, 1960 to Sep 3, 1960 and last saw her/him alive on Sep 3, 1960
Death occurred at 10:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): GEORGE F. SCOFIELD, Capt, MC

22b. ADDRESS: Ft. Leonard Wood, Mo.

22c. DATE SIGNED: 6 Sep 60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 9/4/1960

23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery

23d. LOCATION (City, town or county) (State): St Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS: Hedges Funeral Homes Inc Crocker, Mo

25. DATE RECD. BY LOCAL REG.: 9-6-60

26. REGISTRAR'S SIGNATURE: Carla Jane Anderson

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Clarence Price

Licensed Embalmer No. 4896

P. O. Address Waynesville, N

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