

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-035832

FILED VS OCT 13 1960

310

Primary Registration District No. 3058

Registrar's No. 197

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Charles</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Charles</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>St. Joseph's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2043 N. Main</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Connie</u> Middle <u>Rozell</u> Last <u>McCall</u>				4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1960</u>				
5. SEX <u>Female</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>Sept. 30, 1960</u>	9. AGE (last birthday) <u>23</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>23</u> Min. <u>40</u>		
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>St. Charles, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>		
13a. FATHER'S NAME <u>William Alpha McCall</u>		13b. MOTHER'S MAIDEN NAME <u>Lois Rozell Lambert</u>		14. NAME OF HUSBAND OR WIFE <u>- - - -</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>NONE</u>		17. INFORMANT <u>William McCall - 2043 N. Main, St. Charles Mo.</u>				
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>Atelectasis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>Birth Weight 2 lbs. 12 oz.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>5:15 PM</u> a.m. <u></u> p.m. <u></u>	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 <u>September 30, 1960</u> to <u>Oct 1, 1960</u> and last saw her alive on <u>Oct. 1, 1960</u> Death occurred at <u>5:15 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Paul G. Kocher MD</u> (Degree or title)				22b. ADDRESS <u>St. Charles, Mo.</u>		22c. DATE SIGNED <u>10-2-60</u>		
23a. BURIAL, CREATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct. 2, 1960</u>	23c. NAME OF CEMETERY <u>Lawrence Memorial</u>		23d. LOCATION (City, town, or county) <u>Walnut Ridge, Arkansas</u>		(State)		
24. FUNERAL DIRECTOR <u>H.C. Dallmeyer & Sons Co., St. Charles</u>		ADDRESS <u>Mo.</u>	25. DATE REC'D BY LOCAL REG. <u>Oct 2-60</u>		26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Infant Not Embalmed

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.