

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037429

FILED VS NOV 7 1960

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3006

602

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>Boone</u> | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | a. STATE <u>Mo.</u> | b. COUNTY <u>Camden</u> |
| Length of stay in 1b <u>4 days</u> | | c. CITY OR TOWN <u>Climax Springs</u> | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Medical Center</u> | | d. STREET ADDRESS | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | | |
|--|--------------------------------------|---|--|---|------------------------------------|----------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last | | | 4. DATE OF DEATH Month Day Year | | | |
| <u>Gertrude Walter Elmore</u> | | | <u>Oct. 28 60</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-10-96</u> | 9. AGE (last birthday) <u>64</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Proctor, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> |
| 13a. FATHER'S NAME <u>Henry Walter</u> | | 13b. MOTHER'S MAIDEN NAME <u>Leona Hale</u> | 14. NAME OF HUSBAND OR WIFE <u>Walter Elmore</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>Medical Record Columbia, Mo.</u> |

| | | | | |
|--|-------------------------|---|---|----------------|
| 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) | <u>Bile Peritonitis</u> | | | <u>10 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | <u>Multiple perforations of common duct</u> | | <u>10 days</u> |
| | DUE TO (c) | <u>Multiple gall stones</u> | | <u>years</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"/> 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 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 10/23/60 to 10/28/60 and last saw her/him alive on 10/28/60
Death occurred at 8:00 Am on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | | |
|--|------------------------------------|--|--|---|--|
| 22a. SIGNATURE (Degree or title) <u>Earl J. Wipfle, Jr., M.D.</u> | | 22b. ADDRESS <u>U. of Mo. Medical Center</u> | | 22c. DATE SIGNED <u>10/29/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u> | 23b. DATE <u>Oct 29, 60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u> | 23d. LOCATION (City, town, or county) (State) <u>Camden, Mo</u> | | |
| 24. FUNERAL DIRECTOR <u>Richard James of Service Columbia, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>Oct 29 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</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.

Student _____
Signature of Student Embalmer

Signed Donald L Roberts

Licensed Embalmer No. 4722

P. O. Address Columbia, 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.