

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 24 1960

53

Primary Registration District No. 3010

Registrar's No. 408

-60-037719

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Gir.				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		Length of stay in 1b 1 day		c. CITY OR TOWN Chaffee, Rt. #1		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) between Hamburg & Chaffee		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kevin Middle Wayne Last Welter				4. DATE OF DEATH Month October Day 14 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1959	9. AGE (last birthday) 1	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	IF UNDER 24 HR Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) Cape Girardeau, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME DeWayne Welter			13b. MOTHER'S MAIDEN NAME Barbara Ann Andrews			14. NAME OF HUSBAND OR WIFE NONE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT DeWayne Welter Address Chaffee Rt. #1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumothorax							INTERVAL BETWEEN ONSET AND DEATH 2 or 3 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Tracheostomy							6 hours	
DUE TO (c) Acute laryngotracheobronchitis							20 hours	
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 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 3/29/60 to 10/14/60 and last saw ^{him} her alive on 10-14-60 Death occurred at 7:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Broed M. Hoxworth, M.D.				22b. ADDRESS 24 No. Sprigg Street Cape Girardeau, Missouri			22c. DATE SIGNED 10/17/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-17-1960	23c. NAME OF CEMETERY OR CREMATORY St. Denis Cath. Cemetery		23d. LOCATION (City, town, or county) Benton, Mo.			
24. FUNERAL DIRECTOR Ford & Sons ADDRESS Benton, Mo.			25. DATE RECD. BY LOCAL REG. 10-18-60		26. REGISTRAR'S SIGNATURE James Karter			

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 _____ *W. J. Ford*

Licensed Embalmer No. 5057

P. O. Address Cape Girardeau

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