

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038018

REGISTRATION DISTRICT NO. 128 PRIMARY REGISTRATION DISTRICT NO. 200 REGISTRAR'S NO. 1093A STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>3 day</u>	c. CITY OR TOWN <u>Springfield</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>St. Johns Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2029 W. Scott</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Kay</u> Last <u>Dean</u>	4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</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>10-27-1960</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
----------------------	-------------------------------	---	------------------------------------	---------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	---	---

13a. FATHER'S NAME <u>Paul Dean</u>	13b. MOTHER'S MAIDEN NAME <u>Edna Sneed</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>none</u>	17. INFORMANT <u>Paul Dean</u> Address <u>Springfield, 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>Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.	DUE TO (b) <u>Congenital Heart Disease</u>	
	DUE TO (c) <u>Type Undiagnosed.</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></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
---	--------------------------

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 <u>Springfield, Mo.</u>	COUNTY <u></u> STATE <u></u>
--	--	---	------------------------------

21. I attended the deceased from 10/27/60 to 10/29/60 and last saw her alive on 10/29/60
Death occurred at 1:25 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul L. ...</u> (Degree or title)	22b. ADDRESS <u>609 Cherry St. Springfield Mo.</u>	22c. DATE SIGNED <u>11/9/60</u>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-31, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Republic, Mo.</u>
--	---------------------------------	---	---

24. FUNERAL DIRECTOR <u>W.B. Cantrell Reprulib, Mo.</u>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>11-10-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William B. Coakley

Licensed Embalmer No. 4520

P. O. Address Republic

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.