

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-041018

FILED VS. NOV 21 1960

Registration District No. 38 Primary Registration District No. 3004 Registrar's No. 629

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>16 days</u>		c. CITY OR TOWN <u>Cameron</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>University of Missouri Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>516 Godfrey</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>William</u> Last <u>Christensen</u>				4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>Male</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>4/25/198</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Weston - Iowa</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Chris Ole Christensen</u>			13b. MOTHER'S MAIDEN NAME <u>Anna (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Lela Christensen</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT. Address <u>University of Missouri Medical Records Columbia, Missouri</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>Basilar Artery Thrombosis</u>				<u>8 days</u>		
DUE TO (b)			<u>Polycephemia</u>						
DUE TO (c)			<u>Renal Disease</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 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 a.m. p.m.		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>11/10/60</u> to <u>11/13/60</u> and last saw her him alive on <u>11/13/60</u> Death occurred at <u>9:55 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22. SIGNATURE (Degree or title) <u>Robert E. Bugant M.D.</u>				22b. ADDRESS <u>6401 Dr. Columbia Mo</u>		22c. DATE SIGNED <u>11/14/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11-14-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memory Gardens</u>		23d. LOCATION (City, town, or county) <u>Cameron Mo</u>				
24. FUNERAL DIRECTOR <u>Parber Funeral Service</u>			ADDRESS <u>Columbia</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 12 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
 or by _____, Student Embalmer No. _____
 working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed



Licensed Embalmer No.

4752

P. O. Address

Columbia, Mo.

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