

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041057

STATE FILE NUMBER

FILED VS NOV 21 1960

38 Primary Registration District No. 3006 Registrar's No. 643

1. PLACE OF DEATH a. COUNTY <b>BOONE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Audrain</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>COLUMBIA</b>	Length of stay in lb <b>18 days</b>	c. CITY OR TOWN <b>R.E. 4 - Mexico, Mo.</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Uof. Mo. Medical Center</b>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>REBECCA</b> Middle <b>LEA</b> Last <b>STANFORD</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14, 1957</b>	9. AGE (last birthday) <b>3 years</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Missio 12</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>United States</b>		
13a. FATHER'S NAME <b>WALLACE STANFORD</b>		13b. MOTHER'S MAIDEN NAME <b>MARY JEAN RUNDE</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>Hospital record - U. of Mo. Medical Ctr.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Nephrosis.</b>	
	DUE TO (c)	

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
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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 a.m. p.m.		
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 **2-26-58** to **11-17-60** and last saw her alive on **11-17-60**  
Death occurred at **8:25 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Clément E Brode MD</b>		22b. ADDRESS <b>607 Missoui, Columbia Mo.</b>	22c. DATE SIGNED <b>11/17/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVED</b>	23b. DATE <b>11/17/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEXICO</b>	23d. LOCATION (City, town, or county) (State) <b>Mo.</b>

24. FUNERAL DIRECTOR <b>ARNOLD FUNERAL HOME</b>	ADDRESS <b>Home Mexico, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Nov 17, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>
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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 Geo. S. Whiteaker

Licensed Embalmer No. 4780

P. O. Address Melvin, N

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.