

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041422

FILED VS NOV 29 1960 77

Primary Registration District No. 3016 Registrar's No. 396

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Cole</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFF CITY</u> Length of stay in 1b <u>15 Min.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY _____ c. CITY OR TOWN <u>JEFF CITY, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>910 MOREAU Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MITCHELL</u> Middle <u>GARRETT</u> Last <u>PASLEY</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>NOV. 26, 1960</u>	9. AGE (last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours <u>45</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		11. BIRTHPLACE (City and state or country) <u>JEFFERSON CITY Mo U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>JEAN BARY PASLEY</u>			
13b. MOTHER'S MAIDEN NAME <u>DONNA SUE LEONARD</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>no</u>		17. INFORMANT Address <u>JEAN BARY PASLEY, JEFF CITY, 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>Congenital absence of kidneys, ureters, and urinary bladder.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH	
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 _____ 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>11-26-60 7:30 am.</u> to <u>11-26-60 8 am</u> and last saw her/him alive on <u>11-26-60 8 am</u> Death occurred at <u>11-26-60 8:35 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Harold O Stricker MD</u>		22b. ADDRESS <u>515 E. High Jefferson City</u>		22c. DATE SIGNED <u>11-26-60</u>	
22. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-27-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Callaway Mem. Hlth. Co.</u>		23d. LOCATION (City, town, or county) (State) <u>Callaway Co. Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Morgan Funeral Home, Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Mo. 26 Nov. 1960</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Darrin, MD</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 Marshall C. Blackwell

Licensed Embalmer No. 4713

P. O. Address Fulton, Ga.

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.