

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-045147

FILED VS DEC 19 1960

38

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006

Registrar's No. 691

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in 1b <u>13 days</u> 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"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN <u>Norborne</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route 3</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Eolia</u> Middle <u>Coleman</u> Last <u>Scott</u>			<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>12</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-3-10</u>	<b>9. AGE</b> (last birthday) <u>50</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <u>Norborne, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>United States</u>	
<b>13a. FATHER'S NAME</b> <u>William Coleman</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Marda Stark</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Lewis Scott</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Hospital Chart U.M.M.C.</u>		Address _____	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis (pyogenic shock)</u> DUE TO (b) <u>Terminal carcinoma</u> DUE TO (c) <u>adenocarcinoma of cervix, metastatic</u> 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"/> N- <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <u>12-2-60</u> <b>to</b> <u>12-12-60</u> <b>and last saw her/him alive on</b> <u>12-12-60</u> Death occurred at <u>1255</u> <b>m</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

<b>22a. SIGNATURE</b> (Degree or title) <u>William J. Griffin M.D.</u>		<b>22b. ADDRESS</b> <u>2612 M.C. Columbia, Mo</u>		<b>22c. DATE SIGNED</b> <u>12-12-60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE</b> <u>12-13-1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gilead in Carroll Co</u>	
<b>23d. LOCATION</b> (City, town, or county) (State) <u>Carrollton, Missouri</u>		<b>24. FUNERAL DIRECTOR</b> <u>Parker Funeral Service Columbia</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Dec 13 1960</u>	
<b>26. REGISTRAR'S SIGNATURE</b> <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 JW Phillips  
Licensed Embalmer No. 4897  
P. O. Address Columbia, Md.

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.