

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048409

FILED VS DEC 19 1960

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 307a Registrar's No. 220

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>4 hours</u>		c. CITY OR TOWN <u>Boonville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural route No. I.</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Diana</u> Middle <u>Lynn</u> Last <u>O'Rourke</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11th</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>12-10-1960</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours <u>4</u> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <u>Marshall, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James W. O'Rourke</u>			13b. MOTHER'S MAIDEN NAME <u>Dorothy V. Johnson</u>			14. NAME OF HUSBAND OR WIFE -----	
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>Rural route</u> Address No. <u>I</u> <u>James W. O'Rourke, Boonville 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>Respiratory insufficiency -</u> DUE TO (b) <u>Prematurity - 7mo Butch</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</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>Dec 10</u> to <u>Dec 11</u> and last saw <u>him</u> alive on <u>Dec 11</u> Death occurred at <u>2 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>B. Kleinschmidt M.D.</u> (Degree or title)				22b. ADDRESS <u>Marshall Mo</u>		22c. DATE SIGNED	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-12-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Peninsula cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cooper County Missouri</u>			
24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-12-60</u>		26. REGISTRAR'S SIGNATURE <u>Carl G. Reed</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 _____

R.W. Campbell

Licensed Embalmer No. 3469

P. O. Address Marshall

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.