

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000244

FILED VS JAN 17 1961

38

Primary Registration District No. 3006

Registrar's No. 27

STATE FILE NUMBER

AMENDED

DATE AMENDED

DOCUMENT

| | | | | | | | | |
|--|--|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BOONE | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY MONROE | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia | | Length of stay in lb 31 days | | c. CITY OR TOWN PARIS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION University Medical Center | | | Inside Limit Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) E. CALDWELL ST. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JESSIE Middle FREDRICK Last VANCE | | | | 4. DATE OF DEATH Month 1 - Day 13 - Year 61 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 2-5-86 | | |
| 9. AGE (last birthday) 74 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET'D RAIL ROAD | | | 10b. KIND OF BUSINESS OR INDUSTRY RAILROAD | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY UNITED STATES | |
| 13a. FATHER'S NAME John VANCE | | | 13b. MOTHER'S MAIDEN NAME MARY L. SAGESERE | | | 14. NAME OF HUSBAND OR WIFE NEVA VANCE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN | | | 16. SOCIAL SECURITY NO. YES | | 17. INFORMANT Address University Medical Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracho-Bronchial Aspiration DUE TO (b) Chronic Renal insufficiency DUE TO (c) Diabetic & Atherosclerotic Nephrosclerosis 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 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 min. | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 12-13-60 to 1-13-61 and last saw him alive on 1-13-61 Death occurred at 2:00 p m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Morris Gordon M.D. | | | | 22b. ADDRESS Univ. Hosp. Columbia, Mo | | 22c. DATE SIGNED 1-13-61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 1/15/1961 | | 23c. NAME OF CEMETERY OR CREMATORY MAPLE GROVE CEM. ANDRAIN CO. | | 23d. LOCATION (City, town, or county) (State) MO. | | |
| 24. FUNERAL DIRECTOR E.H. AGNEW | | | | 25. DATE RECD. BY LOCAL REG. Jan 13 1961 | | 26. REGISTRAR'S SIGNATURE Mrs. R.E. Palmer | | |
| ADDRESS PARIS, MO. | | | | | | | | |

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 18 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *E. H. [Signature]*
Licensed Embalmer No. 4000

P. O. Address *Peris, Mo.*

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.