

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000972

FILED VS JAN 30 1961
 AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 80 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 5 months	c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 2646 W. Brower		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2646 W. Brower Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MAROLYN Middle SUE Last HUNTER			4. DATE OF DEATH Month January Day 20 Year 1961		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1960	9. AGE (last birthday) 5 Months 7 Days	IF UNDER 1 YEAR Months 5 Days 7	IF UNDER 24 HR Hours 36 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Springfield, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Jack Hunter	13b. MOTHER'S MAIDEN NAME Nancy Kelling	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT 2646 W. Brower Nancy Kelling, Spgfld, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Likely dehydration		few hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Likely diarrhea, severe	24-36 hrs.
	DUE TO (c) Likely infection, type unknown	36 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) UNATTENDED BY A PHYSICIAN	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
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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.)
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20c. TIME OF INJURY Hour 9:45 A.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 Springfield COUNTY Greene STATE Mo.
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21. I attended the deceased from **9:45 A.M.** to **9:45 A.M.** and last saw **her** alive on **1/23/1961** on the date stated above, and to the best of my knowledge, from the causes stated.

21. SIGNATURE James P. Amos M.D. (Degree or title)	22b. ADDRESS Greene County Health Officer Springfield, Missouri	22c. DATE SIGNED 1-25-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/23/1961	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City, town, or county) (State) Springfield Mo.
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24. FUNERAL DIRECTOR Ralph Thieme ADDRESS 1200 Boonville Spgfld, Mo.	25. DATE RECD. BY LOCAL REG. 1-25-61	26. REGISTRAR'S SIGNATURE Effie G. Melton
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Harold Tubell

Licensed Embalmer No. 5079

P. O. Address Spfld, 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.