

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002036

FILED VS JAN 28 1961

STATE FILE NUMBER

AMENDED

Registration District No. 174 Primary Registration District No. 2035 Registrar's No. 7

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

I

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington			Length of stay in 1b 1 day		c. CITY OR TOWN Lexington Higginsville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) none 119 East 15th	
3. NAME OF DECEASED (Type or print) First Gary Middle Dean Last Mais			4. DATE OF DEATH Month January Day 11 Year 1961				
5. SEX Male	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 January 10 1961	9. AGE (last birthday) 0	IF UNDER 1 YEAR Months 0 Days 1	IF UNDER 24 HR Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Lexington, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Carl D. Mais			13b. MOTHER'S MAIDEN NAME Nancy Lieser			14. NAME OF HUSBAND OR WIFE none	
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. none		17. INFORMANT Address Mrs. Ray Lieser Higginsville, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity							INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____		DUE TO (c) _____		
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 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 <u>1-10-61</u> to <u>1-11-61</u> and last saw <u>him</u> alive on <u>1-11-61</u> . Death occurred at <u>9:55</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert B. Best M.D.				22b. ADDRESS Higginsville, Mo			22c. DATE SIGNED 1-13-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE I-II-1961	23c. NAME OF CEMETERY OR CREMATORY City		23d. LOCATION (City, town, or county) Higginsville, Mo.		(State)	
24. FUNERAL DIRECTOR Forrest A. Hofer Higginsville, Mo.			ADDRESS		25. DATE RECD. BY LOCAL REG. 1-16-61	26. REGISTRAR'S SIGNATURE Minerva E. Swathmore	

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 Forrest R. Hoefler
 Licensed Embalmer No. 480I
 P. O. Address Higginsville, Mo.

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 Forrest R. Hoefler

Licensed Embalmer No. 480I

P. O. Address Higginsville, 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.