

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **008340**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 138 Primary Registration District No. 2000 Registrar's No. 323

FILED APR 1 1961

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) Springfield		Length of stay in 1b 62 years	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 Burge-Protestant		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 613 E. Kearney Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Waymond Middle Fred Last Douglass			4. DATE OF DEATH Month March Day 28 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/21/1898	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	IF UNDER 24 HR. Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY City Utilities Greene Co., Missouri		11. BIRTHPLACE (City and state or country) USA		

13a. FATHER'S NAME Wilford S. Douglass		13b. MOTHER'S MAIDEN NAME Bertha Mc Elhany		14. NAME OF HUSBAND OR WIFE Beuanna Douglass	
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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.		17. INFORMANT Mrs. Beuanna Douglass, Spgfld, MO. Address 613 E. Kearney	
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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: IMMEDIATE CAUSE (a) Cerebral Contusion			INTERVAL BETWEEN ONSET AND DEATH 10 days
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) Multiple fractures - right leg		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 checked="" 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.) auto accident	
20c. TIME OF INJURY Hour 8:30 p.m. Month, Day, Year Mar 18 61			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) city street	20f. CITY, TOWN, OR LOCATION Springfield	COUNTY Greene	STATE Mo
21. I attended the deceased from 18 Mar 61 to 28 Mar 61 and last saw her alive on 28 Mar 61 Death occurred at 11:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Ben M. Deever M.D.		22b. ADDRESS 609 Cherry - Springfield Mo		22c. DATE SIGNED 29 Mar 61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr 1 1961	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City, town, or county) Springfield	(State) Mo.

24. FUNERAL DIRECTOR Ralph Thieme, Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 3-30-61	26. REGISTRAR'S SIGNATURE Effie G. Melton
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

APR 27 1967

APR 18 1967

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 Keith Collier

Licensed Embalmer No. 3632

P. O. Address Springfield

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.