

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008401

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 216C STATE FILE NUMBER

AMENDED
FILED MAR 27 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in lb <u>50 min</u>	c. CITY OR TOWN <u>Republic</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Republic</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>MEIER</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>26</u> Year <u>1961</u>
5. SEX <u>Male</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>2-26-61</u>
10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <u>50</u> Days <u>0</u> Hours <u>0</u> IF UNDER 24 HR: Hours <u>50</u> Min. <u>0</u>
11. BIRTHPLACE (City and state or country) <u>Springfield Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Walter Ernest Meier</u>		13b. MOTHER'S MAIDEN NAME <u>Dollie Josephine Poe</u>	
14. NAME OF HUSBAND OR WIFE <u>Mr Walter E Meier, Box 181, Republic Mo</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mr Walter E Meier, Box 181, Republic 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>Fetal Anoxia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Premature rupture Membranes</u>			<u>2 days</u>
DUE TO (c) <u>Elderly Multipara</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"/> N- <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 <u>1:20</u> a.m. <u>pm</u> Month, Day, Year <u>2-26-61</u>	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>2-26-61</u> to <u>2-26-61</u> and last saw her/him alive on <u>2-26-61</u> Death occurred at <u>1:20 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R.C. Conrad, M.D.</u> (Degree or title)		22b. ADDRESS <u>221 Prof Bldg Spfld Mo</u>	22c. DATE SIGNED <u>2-14-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.H. Lohmeyer F.H. Spfld Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Mellor</u>

DATE AMENDED
 ITEM NO.
 SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 INSTEAD OF

Not Embalmed
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 _____

Licensed Embalmer No. _____

P. O. Address _____

*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.