SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

D APR 7 1961

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2907 -61-011037 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): BARNES HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Chariton

c. CITY OR TOWN: Salisbury — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MARIAN Middle C. Last IMAN

4. DATE OF DEATH: Month MARCH Day 26 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10/10/1921

9. AGE (last birthday): 39 — 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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Salisbury, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Ben Roling

13b. MOTHER'S MAIDEN NAME: Catherine Korte

14. NAME OF HUSBAND OR WIFE: Cleve Iman

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.: Unknown

17. INFORMANT: Cleve Iman, Address: Salisbury, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ACUTE RENAL SHUTDOWN, ETIOLOGY UNDETERMINED — INTERVAL BETWEEN ONSET AND DEATH: 48-72 HOURS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 590X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ACUTE HEMORRHAGIC MYOSITIS

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 MARCH 24, 1961, to MARCH 26, 1961 and last saw her/him alive on MARCH 26, 1961

Death occurred at 8:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. O. Vermillion, M.D. M. D.

22b. ADDRESS: BARNES HOSPITAL

22c. DATE SIGNED: 3/27/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 3-27-61

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State): Gilliam, Mo.

24. FUNERAL DIRECTOR — ADDRESS: Albert H. Hoppe, Inc., 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: MAR 27 1961

26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

SEP 29 1987

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. 365-3

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.