# SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-012667
STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 458

FILED MAY 15 1961

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph — Length of stay in 1b: life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Missouri Methodist Hosp. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Holt
c. CITY OR TOWN: Mound City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: LESLIE Middle: DEAN Last: FAIRCHILD
4. DATE OF DEATH: Month May Day 1 Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4/28/1961
9. AGE (last birthday): —— IF UNDER 1 YEAR: Months —— Days 3 IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ——
10b. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (City and state or country): St. Joseph, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Robert L. Fairchild
13b. MOTHER'S MAIDEN NAME: Boba Steiner
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ——
(If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Robert L. Fairchild, Address: Mound City, 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): RESPIRATORY INSUFFICIENCY — INTERVAL BETWEEN ONSET AND DEATH: 8 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): PREMATURITY — 3 DAYS
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. ☐ 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 BIRTH, to DEATH and last saw her/him alive on 1 MAY 61
Death occurred at 4:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): F Greg Thompson III MD
22b. ADDRESS: 902 Edmond St St Joseph Mo
22c. DATE SIGNED: 3 MAY 61

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 5/2/1961
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Chillicothe, Missouri

24. FUNERAL DIRECTOR ADDRESS: Heaton-Bowman, St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG.: May 5, 1961
26. REGISTRAR'S SIGNATURE: Mrs. Clark Hardill

(Licensed Embalmer's Statement on Reverse Side)

F.G. Thompson III, M.D.

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

**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 _____ Signed Milton Spalding

Signature of Student Embalmer

Licensed Embalmer No. 4595

P. O. Address St Joseph 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.