

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-016332

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 135

AMENDED

FILED MAY 9 1961

1. PLACE OF DEATH 3 1961

a. COUNTY **Adair**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Kirksville** Length of stay in 1b **4 days**

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Kirksville Osteopathic Hosp.** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **Mo.** b. COUNTY **Adair**

c. CITY OR TOWN **Kirksville** Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) **K. O. H.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print)

First **Barbara** Middle **May Ann** Last **Selby**

4. DATE OF DEATH **May 13, 1961**

5. SEX **female** 6. COLOR OR RACE **white** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **5/10/1961** 9. AGE (last birthday) **0** IF UNDER 1 YEAR Months **0** Days **3** IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **infant** 10b. KIND OF BUSINESS OR INDUSTRY **infant** 11. BIRTHPLACE (City and state or country) **Kirksville, Mo.** 12. CITIZEN OF WHAT COUNTRY **U. S. A.**

13a. FATHER'S NAME **DeWayne Selby** 13b. MOTHER'S MAIDEN NAME **Lois Howard** 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 **DeWayne Selby-Npvinger, Mo., Rt. #1** Address

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

IMMEDIATE CAUSE (a) **Medullary Failure**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Anoxia**

DUE TO (c) **Premature Separation of Placenta, Prematurity**

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 Month, Day, Year a.m. p.m.

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 **May 10** to **May 13** and last saw her **alive** on **May 13**. Death occurred at **7:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **[Signature]** (Degree or title) 22b. ADDRESS **Kirksville, Mo** 22c. DATE SIGNED **5/13/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **burial** 23b. DATE **5/15/1961** 23c. NAME OF CEMETERY OR CREMATORY **Bethel** 23d. LOCATION (City, town, or county) (State) **West Grove, Iowa, Davis Co.**

24. FUNERAL DIRECTOR ADDRESS **Dee Riley Funeral Home, Inc., Kirksville, Mo.** 25. DATE RECD. BY LOCAL REG. **May 15, 1961** 26. REGISTRAR'S SIGNATURE **[Signature]**

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

NELSON D. KING, D.D.

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 *Kenneth E. Hayes*

Licensed Embalmer No. 4890

P. O. Address Keokuk, Ia.

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.