

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-016685
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 131

AMENDED

FILED JUN 13 1961

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton, Mo.</u>		Length of stay in 1b <u>8 mo.</u>		c. CITY OR TOWN <u>Columbia, Mo</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>State Hospital No. 1</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 7</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle _____ Last <u>Dennis</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</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>10/15/1876</u>		9. AGE (last birthday) <u>84</u>		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) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u>			11. BIRTHPLACE (City and state or country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Frank Dennis</u>				13b. MOTHER'S MAIDEN NAME <u>Lucy Schooler</u>				14. NAME OF HUSBAND OR WIFE <u>none</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>				16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>State Hospital Records, Fulton, Mo</u> 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) <u>Uremia and Anasarca</u>													
DUE TO (b) <u>acute and chronic pyelonephritis</u>													
DUE TO (c) <u>Nephrolithiasis</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"/> No <input type="checkbox"/> Unknown													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.		Month, Day, Year _____											
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		
21a. attended the deceased from <u>State Hospital No. 1</u>			October 27, 1960			6-8-61			and _____ by _____				
Death occurred at <u>10:35 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
SIGNATURE (Degree or title) <u>James K. Aitterman M.O.</u>						22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo.</u>			22c. DATE SIGNED <u>6/8/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 10, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dripping Springs</u>			23d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>						
24. FUNERAL DIRECTOR <u>Maupin Funeral Home, Fulton, Mo.</u> ADDRESS _____					25. DATE RECD. BY LOCAL REG. <u>June 10 - 1961</u>		26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>						

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Gene C. Yaupein

Licensed Embalmer No. 5092

P. O. Address Falton 140

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.