

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018922

318

1003

4697

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

AMENDED

FILED JUN 2 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN			Length of stay in 1b		c. CITY OR TOWN
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print) LATER IDENTIFIED AS "INFANT DAWSON" UNKNOWN - COL - MALE - INFANT			4. DATE OF DEATH Month Day Year FOUND-DEAD-4-18-61		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR	
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)	12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	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.	17. INFORMANT 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) CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) 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.			INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 7:15 AM m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)			22b. ADDRESS		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY APPROVIT OF

Funeral Director
Rowland-Aker Mortuary Service
4104 M...

DATE RECD. BY LOCAL REG.
MAY 18 1961

REGISTRAR'S SIGNATURE
Loan Smith, M.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 _____

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.