

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028344

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

FILED AUG 21 1961 38 Primary Registration District No. 3006 Registrar's No. 504

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Boone | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Webster | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia | | Length of stay in 1b 10 Days | | c. CITY OR TOWN Marshfield | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION U.M.M.C. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Route 4 | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Michelle Middle Ann Last Burnett | | | | 4. DATE OF DEATH Month August Day 15 Year 1961 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 8/4/61 | 9. AGE (last birthday) II | IF UNDER 1 YEAR Months II Days 11 | IF UNDER 24 HR Hours 11 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Marshfield, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Bonnie Lou Burnett | | | 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 Patient's Hospital Record | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rachischisis with 2nd infect. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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. <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 6:50 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | 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 |
| 21. I attended the deceased from August 5, 1961 to August 15, '61 and last saw her/him alive on August 15, 1961 Death occurred at 6:50 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22. SIGNATURE (Degree or title) Robert Joel Harris M.D. | | | | 22b. ADDRESS University of Missouri Medical Center | | 22c. DATE SIGNED 8/16/61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-17-61 | 23c. NAME OF CEMETERY OR CREMATORY EBENEZER | | 23d. LOCATION (City, town, or county) (State) Sm. E. Marshfield, Mo. | | |
| 24. FUNERAL DIRECTOR Barber Edwards | | | ADDRESS Marshfield, Mo. | | 25. DATE RECD. BY LOCAL REG. Aug 16 1961 | 26. REGISTRAR'S SIGNATURE Mrs R.E. Palmer | |

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 Not Embalmed

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.