

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-028368

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 538

AMENDED

FILED SEP 5 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>	Length of stay in 1b <u>10 hrs. 45 min.</u>	c. CITY OR TOWN <u>Belle</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U.M.M.C.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Gen. Del.</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rocky</u> Middle <u>O'Shea</u> Last <u>McDaniel</u>			4. DATE OF DEATH Month <u>8</u> Day <u>26</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>8-26-61</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>10</u> Days <u>45</u>	IF UNDER 24 HR Hours <u>10</u> Min. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Bert McDaniel</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Branson</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Chart UMMC, Columbia 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>Respiratory Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs 45 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Prematurity</u>	
	DUE TO (c) <u>—</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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>—</u> a.m. <u>—</u> 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
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21. I attended the deceased from 8/26/61 4:30 A.M. to 8/26/61 3:13 P.M. and last saw her/him alive on 8/26/61
Death occurred at 3:13 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. Peter Ekern M.D.</u>	22b. ADDRESS <u>Univ. Hosp., Columbia</u>	22c. DATE SIGNED <u>8-27-61</u>
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23a. BURIAL, REMOVAL, SPECIFY	23b. DATE <u>8-29-61</u>	23c. NAME OF CEMETERY OR OREMATORY <u>anatomical Bank</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>
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24. FUNERAL DIRECTOR <u>J. O. Roberts</u>	ADDRESS <u>Columbia MO</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 29 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mr. R. E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 INSTEAD OF

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.