

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028842

STATE FILE NUMBER

Registration District No. 446 Primary Registration District No. 3020 Registrar's No. 202

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT. MEDICAL CERTIFICATION BY AFFIDAVIT OF

FILED SEP 5 1961

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Union</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>ALLEN</u> Last <u>MINKS</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>27</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>8-26-1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <input checked="" type="checkbox"/>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	9. AGE (last birthday) <input checked="" type="checkbox"/> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. <u>6</u>
11. BIRTHPLACE (City and state or country) <u>Washington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Peter Minks</u>		13b. MOTHER'S MAIDEN NAME <u>Shurley Stickford</u>	
14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Address <u>Mrs. Peter Minks, Union, Mo.</u>	
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>pulmonary failure</u> DUE TO (b) <u>immaturity (approx 4 mos)</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hrs</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 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	
21. I attended the deceased from <u>8-26-61</u> to <u>8-27-61</u> and last saw her/him alive on <u>8-26-61</u> Death occurred at <u>4:50 A.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Geo. C. Richardson, M.D.</u> (Degree or title)		22b. ADDRESS <u>Union, Mo.</u>	
22c. DATE SIGNED <u>28 Aug 61</u> (State)		23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Aug 28, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Washington, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>Nieburg & Witt Inc. Washington, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>8/28/61</u>		26. REGISTRAR'S SIGNATURE <u>Leola C. Siskmann</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Vernon C. Vedder

Licensed Embalmer No. 5031

P. O. Address Washington, T

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.