MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-028972
STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 802

FILED SEP 5 1961

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Length of stay in 1b 1½ Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOCTORS' MEMORIAL HOSPITAL — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY WEBSTER
c. CITY OR TOWN Strafford — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Box 174 Route 1 — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First KAREN Middle SUE Last TERRY
4. DATE OF DEATH Month August Day 26 Year 1961
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 8/24/61
9. AGE (last birthday) — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours 36, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born
10b. KIND OF BUSINESS OR INDUSTRY -----
11. BIRTHPLACE (City and state or country) Marshfield, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Calvin Terry
13b. MOTHER'S MAIDEN NAME Henrietta Hildebrand
14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. & Mrs. Calvin Terry Address Marshfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Medullary Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Anoxemia
DUE TO (c) Prolapse of Umbical cord during delivery
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 8/24/61 to 8/26/61 and last saw her alive on 8/26/61
Death occurred at 12:15 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Leland E Witzel (Degree or title) D.O.
22b. ADDRESS Springfield Mo
22c. DATE SIGNED 8/26/61
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 8-26-1961
23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD
23d. LOCATION (City, town, or county) MARSHFIELD (State) MO
24. FUNERAL DIRECTOR BARBER-EDWARDS ADDRESS MARSHFIELD
25. DATE RECD. BY LOCAL REG. 8-29-61
26. REGISTRAR'S SIGNATURE Effie L. Melton

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

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.