

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032491

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Dr. White
 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 960

STATE FILE NUMBER

FILED OCT 16 1961

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| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | Length of stay in 1b 2 DAYS | c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 621 S. HAMPTON Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL FARRIS | | | 4. DATE OF DEATH Month Day Year OCT. 11, 1961 | |
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| 5. SEX MALE | 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 10/9/61 | 9. AGE (last birthday) 24 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO. | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME VICTOR FARRIS | 13b. MOTHER'S MAIDEN NAME JEANNETT AYOUB | 14. NAME OF HUSBAND OR WIFE X |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. NO | 17. INFORMANT Address VICTOR FARRIS, SPRINGFIELD, MO. |
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| 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>Hyaline Membrane</u> DUE TO (b) <u>Atelactasis</u> DUE TO (c) <u>Intra-uterine</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> |
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| 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.) |
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| 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 |
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| 21. I attended the deceased from <u>9 Oct</u> to <u>11 Oct</u> and last saw her/him alive on <u>11 Oct</u> Death occurred at <u>1 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>A. White M.D.</u> | 22b. ADDRESS <u>205 Professional Bldg</u> | 22c. DATE SIGNED <u>12 Oct 61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 10/12/61 | 23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY | 23d. LOCATION (City, town, or county) SPRINGFIELD, MO. |
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| 24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO. | 25. DATE RECD. BY LOCAL REG. 10-12-61 | 26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u> |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT 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 H. J. McCann

Licensed Embalmer No. 2727

P. O. Address Appld

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.