

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033261

STATE FILE NUMBER

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 475

FILED SEP 26 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Length of stay in 1b		c. CITY OR TOWN <u>Independence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sanitarium and Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1412 Kensington</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ann</u> Last <u>Sprague</u>				4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1961</u>							
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-1961</u>		9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours <u>9</u> Min. <u>37</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country) <u>Independence Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>William Harold Sprague</u>				13b. MOTHER'S MAIDEN NAME <u>Jacqueline Inez Smith</u>				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. <u>none</u>		17. INFORMANT <u>Wm. H. Sprague</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>Prematurity - 5+ wks -</u> DUE TO (b) <u>Probable hyaline membrane disease 1 day</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										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. <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 _____ 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>9-5-61</u> to <u>9-6-61</u> and last saw her <u>live</u> alive on <u>9-6-61</u> Death occurred at _____ a.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>Paul Bachman MD</u>						22b. ADDRESS <u>Indep. Mo</u>			22c. DATE SIGNED <u>9-11-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE <u>9-11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Independence Mo</u>				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR <u>Independence Sanitarium + Hospital</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-17-61</u>		26. REGISTRAR'S SIGNATURE <u>Alba Craig</u>			

DOCUMENT

MEDICAL CERTIFICATION

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 _____

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.