

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-035883

STATE FILE NUMBER

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 665  
**FILED NOV 6 1961**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Boone</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Knox</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UMMC</u>		Length of stay in 1b <u>18 days</u>		c. CITY OR TOWN <u>Edina</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Ellis</u> Middle <u>Ray</u> Last <u>Little</u>		d. STREET ADDRESS (If outside, give location) <u>RT. 3</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1961</u>		8. DATE OF BIRTH <u>7-26-61</u>	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		9. AGE (last birthday) <u>9</u> Months <u>80</u> Days <u>0</u> Hours <u>0</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) <u>Kirkville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Ellis Little</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Ruth Alberta Clark</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>		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>—</u>		17. INFORMANT <u>Chart UMMC</u>		Address <u>—</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>Intracranial Bleeding</u>		DUE TO (b) <u>Thrombocytopenia</u>		DUE TO (c) <u>Toxoplasmosis, Congenital</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 months</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 <u>—</u> a.m. <u>—</u> p.m. <u>—</u> Month, Day, Year <u>—</u>		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>October 13, 1961</u> , to <u>November 2, 1961</u> and last saw her alive on <u>November 2, 1961</u>		Death occurred at <u>12:50 pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Robert Joel Harris, M.D.</u>		22b. ADDRESS <u>UMMC Columbia Miss. 11/2/61</u>	
22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11-3-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LINVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>EDINA, MISSOURI</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>Parker Funeral Service, Columbia, Mo.</u>		ADDRESS <u>—</u>		25. DATE RECD. BY LOCAL REG. <u>Nov 3 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 Joe Kullbi  
Licensed Embalmer No. 4897  
P. O. Address Columbus, Ga

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.