

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040120

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 688

FILED NOV 20 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | | Length of stay in 1b <u>11 Days</u> | c. CITY OR TOWN <u>Columbia</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Missouri Medical Center</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>ROUTE 3</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Gilbert Clarence Mockbee</u> | | | 4. DATE OF DEATH Month Day Year <u>November 11 1961</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-1-86</u> |
| 9. AGE (last birthday) <u>75</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | 11. BIRTHPLACE (City and state or country) <u>Boone Co., Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | 13a. FATHER'S NAME <u>James Mockbee</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Liza Nichols</u> | | 14. NAME OF HUSBAND OR WIFE <u>BEULAH MOCKBEE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | 16. SOCIAL SECURITY NO. <u>Yes</u> | 17. INFORMANT <u>University of Mo. Medical Records</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>Pulmonary obstruction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchiogenic Carcinoma</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 years</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 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.) | |
| 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>11-1-61</u> to <u>11-11-61</u> and last saw him alive on <u>11-11-61</u> Death occurred at <u>9:15</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Earl Russell MD</u> | | 22b. ADDRESS <u>Ummc Columbia, Mo</u> | 22c. DATE SIGNED <u>11-11-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-13-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Lyman Sprinkle, Columbia, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Nov 18 1961</u> | 26. REGISTRAR'S SIGNATURE <u>R.E. Palmer</u> |

NOV 27 1961

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 Richard A. Leever

Licensed Embalmer No. 5109

P. O. Address Columbia, Mo.

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.