

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041646

Registration District No. 985 Primary Registration District No. 3089 Registrar's No. 12997 STATE FILE NUMBER

AMENDED

FILED NOV 20 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

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|--|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Linn</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> | Length of stay in lb <u>1 day</u> | c. CITY OR TOWN <u>St. Catherine</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>Perishing Memorial Hospital</u> | | d. STREET ADDRESS <u>P.O. Box # 10</u> | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Infant M^c Adams</u> | | | 4. DATE OF DEATH Month Day Year <u>November 12, 1961</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/11/1961</u> | 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 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>Brookfield, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Glynda M^c Adams</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</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. | 17. INFORMANT Address <u>Elizabeth M^c Adams St Catherine, Mo</u> | | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> |
| IMMEDIATE CAUSE (a) <u>Spontaneous pneumothorax</u> | | |
| Conditions, if any, which gave rise above cause (a), stating the underlying cause last. DUE TO (b) <u>Pneumonia</u> | | |
| DUE TO (c) <u>Prematurity</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 (e) <u>Premature infant birth</u> | | 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.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |

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| 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 11-11-61 to 11-12-61 and last saw her/him alive on 11-12-61
Death occurred at 7:30 a.m. 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>R.L. Pugh D.O.</u> | 22b. ADDRESS <u>Brookfield Mo.</u> | 22c. DATE SIGNED <u>11-13-61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11/13/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Hiel Funeral Home Brookfield, Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>11-10-61</u> | 26. REGISTRAR'S SIGNATURE <u>Anna Watson</u> |
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ITEM NO. 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 ^{not embalmed} ~~embalmed by me,~~
or by due to prematurity, Student Embalmer No. _____,
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Hill Funeral Home
Helen R. Roberts, Funeral

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.