

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-000256

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 2A

FILED JAN 22 1962

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>St. Charles</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>O'Fallon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univer. of Mo. Med Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>615 Westhoff</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lee</u> Last <u>Mead</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1962</u>		
5. SEX <u>Male</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>1-6-62</u>	9. AGE (last birthday) <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>30</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>Missouri, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Janet Mead</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="radio"/> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>U.M.M.C. 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>Respiratory Depression</u>					INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Meningitis, E. Coli</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 _____ s.m. _____ p.m. _____		Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1/11/62</u> to <u>1/13/62</u> and last saw <u>him</u> alive on <u>1/13/62</u> Death occurred at <u>1:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert J. Harris</u>			22b. ADDRESS <u>University Hospital Missouri</u>		22c. DATE SIGNED <u>1/14/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-16-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zoar Carr</u>		23d. LOCATION (City, town, or county) (State) <u>Lincoln County Mo</u>
24. FUNERAL DIRECTOR <u>A. W. McCoy</u>		ADDRESS <u>Tracy St</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 15 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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.

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Length of stay in 1b 3 da	c. CITY OR TOWN O'Fallon Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION University Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 615 Westhoff Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDWARD Middle LEE Last MEAD			4. DATE OF DEATH Month Jan Day 13 Year 1962
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 Jan. 6, 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Troy Mo.	9. AGE (last birthday) IF UNDER 1 YEAR: Months _____ Days 7 IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) Troy Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Jerry Wm. Crane		13b. MOTHER'S MAIDEN NAME Janet Mead	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) None		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Lorene Keeschulte O'Fallon Mo 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) _____ DUE TO (b) _____ 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 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 checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 16, 1962	23c. NAME OF CEMETERY OR CREMATORY Zoar Cemetery	23d. LOCATION (City, town, or county) (State) Lincoln County MO.
24. FUNERAL DIRECTOR ADDRESS D.W. Mabey Troy Mo.		25. DATE RECD. BY LOCAL REG. 1-15-62	26. REGISTRAR'S SIGNATURE Mrs R.E. Palmer

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JAN

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 D. C. McLaughlin
Licensed Embalmer No. 3586

P. O. Address Troy 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.