

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED MAR 19 1962

38

Primary Registration District No.

3006

Registrar's No.

161

=62-009855

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Calloway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>4hr. 13Min.</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Boone County Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>907 West Morningside</b>	
3. NAME OF DECEASED (Type or print) First <b>Kimberly</b> Middle <b>Joan</b> Last <b>Acton</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-16-62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME <b>Clyde Stanley Acton</b>		11b. MOTHER'S MAIDEN NAME <b>Delores Elverie Knight</b>	
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. <b>-----</b>	
17. INFORMANT <b>Clyde S. Acton, Fulton, Missouri</b>		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) <b>Neonatal Atelectasis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Prematurity</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Congenital Esophageal Atresia</b> 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.) <b>-----</b>		20c. TIME OF INJURY Hour <b>-----</b> a.m. <b>-----</b> p.m. <b>-----</b> Month, Day, Year <b>-----</b>	
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.) <b>-----</b>	
20f. CITY, TOWN, OR LOCATION <b>Columbia</b>		COUNTY <b>Missouri</b> STATE <b>-----</b>	
21. I attended the deceased from <b>3-16-62</b> to <b>3-16-62</b> and last saw her alive on <b>3-16-62</b> Death occurred at <b>6:46</b> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Charles Scheuber MD</b>		22b. ADDRESS <b>Columbia, Missouri</b>	
22c. DATE SIGNED <b>16 March 1962</b>		22d. LOCATION (City, town, or county) (State) <b>Columbia, Missouri</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/16/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Columbia, Missouri</b>	
24. FUNERAL DIRECTOR <b>Lyman Sprinkle Columbia, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Mar 16, 1962</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>	

(Licensed Embalmer's Statement on Reverse Side)

Dr. Scheuber.

USE BLACK INK

OR

TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>NOT</sup> ~~was~~ embalmed ~~by me,~~

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Lynnan Sprinkle*

Licensed Embalmer No. 4013

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.