

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019892
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 67

FILED MAY 24 1962

VS 300
Rev. 4/59

1 0850
2 0850
3 2
4 1
5 0
6
7 0
8 1
9 7680
10
11
12 2-0
13 1-0

DATE AMENDED
6/11/62
6/11/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
pending laboratory studies

ITEM NO. SHOULD READ
18a Interstial pneumonia
18b viral sepsis

BY AFFIDAVIT OF attending physician
DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fort Leonard Wood</u>		c. CITY OR TOWN <u>Fort Leonard Wood</u>	
Length of stay in lb		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>US Army Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>26 Williams</u>	
3. NAME OF DECEASED (Type or print) First <u>MARITHERESE</u> Middle <u>REUTER</u> Last <u>REUTER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1962</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>7 May 1962</u>
9. AGE (last birthday) <u>-</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (City and state or country) <u>Ft Leonard Wood, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jack L. Reuter</u>		13b. MOTHER'S MAIDEN NAME <u>Marifran A. Mc Farland</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) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Jack L. Reuter</u> Address <u>26 Williams Fort Leonard Wood, Mo.</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>- Undetermined (Pending Laboratory Studies) -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Viral sepsis</u> DUE TO (c) _____ 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			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>36 hrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.	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 <u>Fort Leonard Wood, Missouri</u>
21. I attended the deceased from <u>15 May 1962</u> to <u>16 May 1962</u> and last saw her <u>XXX</u> alive on <u>16 May 1962</u> Death occurred at <u>4:45 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS <u>US Army Hospital Fort Leonard Wood, Missouri</u>	
22a. SIGNATURE <u>LYMAN V. OLSEN, Major, MC</u>		22c. DATE SIGNED <u>5-16-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 17, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cavalry Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>Moss-Williams Waynesville Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>5-17-62</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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 was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarice Those

Licensed Embalmer No. 4896

P. O. Address Waynesville 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.