

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-021813
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 002 Primary Registration District No. 5017 Registrar's No. 42

FILED JUN 21 1962

VS 300
Rev. 4/59

0020
25117

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4 0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANDREW</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>BUCHANAN</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nodaway township</u> Length of stay in lb | | c. CITY OR TOWN <u>St. Joseph</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>4 miles north of Savannah Mo on US-71 Highway</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>2310 No. 2ND St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD FRANCIS Soper</u> | | | 4. DATE OF DEATH Month Day Year <u>June 16 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>7-15-42</u> |
| 9. AGE (last birthday) <u>19</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYVILLE St. College</u> | 11. BIRTHPLACE (City and state or country) <u>Portsmouth VA.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>DONALD F. Soper</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>MARY V. MARTIN</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) <u>No</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address <u>2210 N 2ND ST. St. Joseph</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>Cerebral concussion</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Removal of portions of temporal and occipital bone.</u> | | | " |
| DUE TO (c) <u>Automobile accident.</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 checked="" 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.) <u>Automobile in which he was riding was</u> | |
| 20c. TIME OF INJURY Hour Month, Day, Year <u>11:45 June 16, 1962</u> struck by a truck, throwing him to pavement from car. | | | |
| 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.) <u>US-71 Highway</u> | 20f. CITY, TOWN, OR LOCATION <u>Nodaway township</u> | COUNTY STATE <u>Andrew Mo.</u> |
| 21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at <u>11:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Death or title) <u>W. S. Maxwell, D.O.</u> | | 22b. ADDRESS <u>307 W. Main, Savannah, Mo.</u> | 22c. DATE SIGNED <u>6/18/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>6-19-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Breck & Hawthorn Funeral Home Savannah Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-18-62</u> | 26. REGISTRAR'S SIGNATURE <u>William Sparks</u> |

USE BLACK INK OR TYPEWRITER RIBBON

MAR 8 1963

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Javonmahus

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.