

# Dr. Auner

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-022679  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 981

<b>FILED JUL 2 1962</b>	
1. PLACE OF DEATH	
a. COUNTY <b>GREENE</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>SPRINGFIELD</b>	a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>
Length of stay in 1b <b>6 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>	d. STREET ADDRESS (If outside, give location) <b>MOTOR INN MOTEL</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED	
First <b>JAMES</b> Middle <b>A.</b> Last <b>ROUTT</b>	4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1/31/88</b>
9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MANAGER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>
11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>B.L. ROUTT</b>	13b. MOTHER'S MAIDEN NAME <b>JOSEPHINE WOOD</b>
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) <b>NO</b>	16. SOCIAL SECURITY NO.
17. INFORMANT <b>ALLEN E. ROUTT, SPRINGFIELD, MO.</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>Acute Broncho-pneumonia</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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>Chronic cardio-vascular disease - atherosclerosis</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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 <b>1859</b> to <b>6-22-62</b> and last saw her/him alive on <b>6-22-62</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>7:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Walter Auner MD</b> (Degree or title)	22b. ADDRESS <b>600 S. Glenstone Springfield, Mo</b>
	22c. DATE SIGNED <b>6-25-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE
23c. NAME OF CEMETERY OR CREMATORY <b>HAZELWOOD</b>	
23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>	
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER FUNERAL HOME</b> ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>6-27-62</b>
26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Ceil Auner M.D.  
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 Julian T. Swadley

Licensed Embalmer No. 4815

P. O. Address Springfield

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.

Permit record 6-25-63