

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-026039

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 434

FILED AUG 6 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
Rev. 4/59		
8109	INSTEAD OF	DOCUMENT
20795		
3		
4 0		
5 0		
6		
7 0		
8 1		
9757.3		
10		
11		
12 0	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
13 0		
	SHOULD READ	
	ITEM NO.	

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY PEMISCOT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COLUMBIA		c. CITY OR TOWN CARUTHERSVILLE	
Length of stay in 1b 46 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIV. OF MO. MED. CENTER		d. STREET ADDRESS (If outside, give location) 1105 MADISON	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First STANLEY Middle NIEL Last MALONE			4. DATE OF DEATH Month JULY Day 31 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 9-20-51
9. AGE (last birthday) 10 YR. 10		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)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Caruthersville Mo
12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME JAMES MALONE		13b. MOTHER'S MAIDEN NAME CHARLENE WILSON	
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) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Hospital Records		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) CARDIAC FAILURE, PULM. EDEMA			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) AZOTEMIA, HYPERTENSIVE VASC			
DUE TO (c) CONGENITAL ABSENCE (L) KIDNEY, ATROPHIC (R) KIDNEY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) RETINOPATHY, CEREBRO-VASC. ACCIDENT			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 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 Month, Day, Year s.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		COUNTY STATE	
21. I attended the deceased from 7/23/62 to 7/31/62 and last saw her/him alive on 7/31/62 6:00 PM Death occurred at 6:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wm E. Herman, M.D.		22b. ADDRESS UNIV. MED. CENTER	
22c. DATE SIGNED 7/31/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-4-62	23c. NAME OF CEMETERY OR CREMATORY Caruthersville	23d. LOCATION (City, town, or county) (State) Caruthersville Mo
24. FUNERAL DIRECTOR Lynwood Spradell, Columbia, Mo.		25. DATE RECD. BY LOCAL REG. Aug 9 1962	26. REGISTRAR'S SIGNATURE Mrs R E Palmer

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

Lynard 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.