

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-026788

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 200 Primary Registration District No. 1080 Registrar's No. 1080

FILED JUL 28 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in lb 15 YRS.	c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 818 CONCORD		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last PAULA ANN TEDLOCK			4. DATE OF DEATH Month Day Year JULY 12 1962		
5. SEX FEMALE	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 6/8/47	9. AGE (last birthday) 15	IF UNDER 1 YEAR Months Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME PAUL R. TEDLOCK		13b. MOTHER'S MAIDEN NAME PAULINE LEACH		14. NAME OF HUSBAND OR WIFE X	
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 Address PAUL R. TEDLOCK, SPRINGFIELD, MO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>post operative Hemorrhage</i>					<i>4 hrs</i>
DUE TO (b) <i>afibrinogenemia</i>					<i>4 hrs</i>
DUE TO (c) <i>Extracorporeal circulation for Surgical Repair</i>					<i>10 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <i>Introlology of Fallot - 15th yrs.</i>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 a.m. p.m. Month, Day, Year	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 <i>7-9-62</i> to <i>7-12-62</i> and last saw her alive on <i>7-12-62</i> Death occurred at <i>7:15 P.M.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>T. E. Ashley M.D.</i>			22b. ADDRESS <i>Springfield Mo</i>		22c. DATE SIGNED <i>7-13-62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/14/62	23c. NAME OF CEMETERY OR CREMATORY WHITE CHAPEL	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.		
24. FUNERAL DIRECTOR ADDRESS H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 7-16-62	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>		

T. E. Ashley
USE BLACKINK 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 *J. McLean*

Licensed Embalmer No. 2727

P. O. Address *[Signature]*

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
7-13-63