

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-030023

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 493

FILED SEP 4 1962

VS 300
Rev. 4/59

0109
20220

3
4 0
5 1
6
7 0
8 1
9 X
10
11 0.22
12 2.0
13 3-0

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 <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Christian</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>			Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>Chadwick</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) <u>University of Missouri Medical Center</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>UNKNOWN</u>			
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>James</u> Last <u>Gray</u>			4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1962</u>						
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-34</u>	9. AGE (last birthday) <u>28</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Logger</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		
13a. FATHER'S NAME <u>Reggie Gray</u>			13b. MOTHER'S MAIDEN NAME <u>Elsie Allen</u>			14. NAME OF HUSBAND OR WIFE <u>Wilma Gray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records - Columbia, Mo.</u> Address <u> </u>				
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) <u>CESSATION OF PULSE + RESPIRATION</u>							<u>IMMEDIATE</u>		
DUE TO (b) <u>RENAL SHUT DOWN</u>							<u>9 days</u>		
DUE TO (c) <u>MULTIPLE FRACTURES + INJURIES.</u>							<u>9 days.</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>PT WAS CRUSHED 2 LOGS WHILE IN CAB OF TRUCK</u>							
20c. TIME OF INJURY Hour <u>3:30</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Month, Day, Year <u>8-21-62</u>								
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>ROAD MISSOURI # 125</u>		20f. CITY, TOWN, OR LOCATION <u>GARRISON-BRANDWICK</u>		COUNTY <u>CHRISTIAN</u>		STATE <u>CO.</u>	
21. I attended the deceased from <u>8-25-62</u> to <u>8-30-62</u> and last saw her <u>alive</u> on <u>8-30-62</u> Death occurred at <u>7:20 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John M. Laird, Jr M.D.</u> (Degree or title)				22b. ADDRESS <u>M.U. Medical Center</u>				22c. DATE SIGNED <u>8-30-62</u>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Reinterment</u>		23b. DATE <u>Aug. 31, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chadwick Cemetery</u>		23d. LOCATION (City, town, or county) <u>Chadwick, Mo.</u>			(State)	
24. FUNERAL DIRECTOR <u>Parker Funeral Service, Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Aug 31, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</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

George A. Keeby

Licensed Embalmer No. 4752

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.