

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-037623**  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 602

**FILED OCT 29 1962**

VS 300  
Rev. 4/59  
6109  
20735  
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4 0  
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DATE AMENDED  
11/2/62  
11/2/62  
11/2/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
RENAI FAILURE  
HEPATIC FAILURE  
HEPATIC FAILURE

BY AFFIDAVIT OF attending physician  
DOCUMENT

MEDICAL CERTIFICATION  
18a Hepatic & Renal Failure  
18c Cholelithiasis & Cholelithiasis  
left blank

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>NEWTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>COLUMBIA</u>		Length of stay in lb <u>31 DAYS</u>	c. CITY OR TOWN <u>NEOSHO</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY OF MISSOURI INSTITUTION <u>MEDICAL CENTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>510 W. SPRING ST.</u>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WINFIELD</u> Last <u>BAUGHER</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>19</u> Year <u>1962</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REALTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	11. BIRTHPLACE (City and state or country) <u>MO</u>
13a. FATHER'S NAME <u>DANIEL BAUGHER</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH DEACON</u>	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)		17. INFORMANT <u>UNIVERSITY OF MISSOURI MEDICAL RECORDS</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>RENAL FAILURE</u>		HEPATIC & <u>RENAL FAILURE</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>POST-OP CHOLECYSTECTOMY + CHOLEDOCHOSTOMY</u>		3 wks.	
DUE TO (c) <u>CHOLELITHIASIS &amp; CHOLEDOCHOLITHIASIS</u>		YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HEPATIC FAILURE</u>			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 _____ 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 COUNTY STATE		
21. I attended the deceased from <u>9-19-62</u> to <u>10-19-62</u> and last saw her/him alive on <u>10-19-62</u> Death occurred at <u>9:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deed or title) <u>Em Richard Jones M.D.</u>		22b. ADDRESS <u>Univ. Mo Med. Center</u>	22c. DATE SIGNED <u>10/20/62</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Funeral</u>	23b. DATE <u>10-22-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IOOF</u>	23d. LOCATION (City, town, or county) (State) <u>Neosho, Mo.</u>
24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u>	ADDRESS <u>Columbia Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 20 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

*Lynard J. Jumble*

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.

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