

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-037653

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 600

FILED OCT 22 1962

VS 300
Rev. 4/59

1 0109
2 0269
3
4 0
5 1
6
7 0
8 2
9 9160
10 16
11 064
12 2-0
13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

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>Mo</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>Jefferson City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univ. of Mo Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>110 West Ashley St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oliver Sylvester Perkins</u>			4. DATE OF DEATH Month Day Year <u>Oct 19 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>4-14-89</u>
9. AGE (last birthday) <u>73</u>		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) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bland Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Irvin Perkins</u>	
13b. MOTHER'S MAIDEN NAME <u>Virginia Connoll</u>		14. NAME OF HUSBAND OR WIFE <u>Rosa K Perkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Medical Records UMMC</u> 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) <u>Acute pulmonary Edema</u> DUE TO (b) <u>Burns 20% 2°</u> DUE TO (c) <u>Gas Explosion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 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>Gas Explosion in Home</u>	
20c. TIME OF INJURY <u>2:00 a.m.</u> Month, Day, Year <u>10 14 62</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Eldon</u>	COUNTY STATE <u>Miller Mo</u>
21. I attended the deceased from <u>10-14-62</u> to <u>Death</u> and last saw her alive on <u>10-19-62</u> Death occurred at <u>5:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>L. B. Russell MD</u> (Degree or title)		22b. ADDRESS <u>UMMC Columbia, Mo</u>	22c. DATE SIGNED <u>9-19-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-22-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Belle Cam</u>	23d. LOCATION (City, town, or county) (State) <u>Belle Mo</u>
24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u> ADDRESS <u>Columbia, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 19 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

USE BLACK INK
OR
TYPEWRITER RIBBON

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MEDICAL CERTIFICATION

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Explosion Burns 20% 2°
DUE TO (c) 5 days

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.

Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT SUICIDE HOMICIDE
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
Gas Explosion in Home

20c. TIME OF INJURY
Hour 8 a.m. p.m.
Month, Day, Year 10-14-62

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home
20f. CITY, TOWN, OR LOCATION
Eldon
COUNTY Miller STATE MO

21. I attended the deceased from 10-14-62 to Death and last saw him alive on 10-14-62
Death occurred at 5:38 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Earl Russell MD (Degree or title)
22b. ADDRESS U.M.M.C. Columbia
22c. DATE SIGNED 10-19-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-22-1962
23c. NAME OF CEMETERY OR CREMATORY Belle
23d. LOCATION (City, town, or county) (State) Belle, Mo.

24. FUNERAL DIRECTOR Lyman Sprinkle mo. ADDRESS Columbia
25. DATE RECD. BY LOCAL REG. Oct 19 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

Anna Louise Jones

Licensed Embalmer No.

4411

P. O. Address

Belle Me

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.