

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-041629

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 657

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 26 1962

VS 300
Rev. 4/59

1 0109
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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 <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>1 1/2 Days</u>	c. CITY OR TOWN <u>New Florence</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MO. MEDICAL CENTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JEFFERY</u> Middle <u>ALAN</u> Last <u>Sheets</u>			4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>62</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINOR</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (last birthday) <u>1</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ralph Edward Sheets</u>		13b. MOTHER'S MAIDEN NAME <u>Alberta Cash</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) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>University of Mo. Medical Records</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>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>98 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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 <u>11-20-62</u> to <u>11-22-62</u> and last saw her/him alive on <u>11-22-62</u> . Death occurred at <u>2:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold P. Martin M.D.</u>		22b. ADDRESS <u>U M M C Columbia, Mo.</u>	22c. DATE SIGNED <u>11-22-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-23-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Florence Cemetery</u>	23d. LOCATION (City, town, or county) <u>New Florence Mo</u> (State) _____
24. FUNERAL DIRECTOR ADDRESS <u>D B Baber New Florence Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov 22, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>

USE BLACK INK OR TYPEWRITER RIBBON

NOV 27 1962

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 W B Baker

Licensed Embalmer No. 3375

P. O. Address New Haven 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.