

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000231

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 5006 Registrar's No. 22

FILED JAN 14 1963

VS 300
Rev. 4/59

1 0109

2 1120

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4 0

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9 759.0

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12 2-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>Marshfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. of Mo. Med. Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Dale</u> Middle <u>Wayne</u> Last <u>Dill</u>			4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1963</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>1-3-63</u>	9. AGE (last birthday) Months <u>6</u> Days <u>6</u> Hours <u></u> Min. <u></u>	IF UNDER 1 YEAR IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Columbia, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>United States</u>
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13a. FATHER'S NAME <u>Ralph Wayne Dill</u>	13b. MOTHER'S MAIDEN NAME <u>Edith Ann Silkey</u>	14. NAME OF HUSBAND OR WIFE <u>U. of Mo. Medical Records</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>U. of Mo. Medical Records</u> Address
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18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>AGENESIS OF LUNG</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS+</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>SEPSIS</u>		<u>3 DAYS</u>
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
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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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> 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 <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>JAN. 3, 1963</u> to <u>JAN. 9, 1963</u> and last saw him/her alive on <u>JAN. 9, 1963</u> . Death occurred at <u>5:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Montgomery</u>	22b. ADDRESS <u>UNIVERSITY MEDICAL CTR</u>	22c. DATE SIGNED <u>1/9/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-12-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cann Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dallas County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Montgomery Funeral Home</u> ADDRESS <u>BUFFALO, Mo.</u>	25. DATE REC'D. BY LOCAL REG. <u>Jan 10, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mr. R. E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Herman H. Vreeta*

Licensed Embalmer No. 5083

P. O. Address Buffalo, 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.