

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-005247**

STATE FILE NUMBER

Registration District No. 38

Primary Registration District No. 5120

Registrar's No. 168

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0100

2 0100

3 2

4 1

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7 0

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11

12 90-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED MAR 7 1963</b>	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Boone</u></p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hallsville Columbia</u> Length of stay in 1b <u>life</u></p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.R. #1 Hallsville, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u></p> <p>c. CITY OR TOWN <u>Hallsville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (if outside, give location) <u>RR #-+-----</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last</p> <p><u>Patricia Machele Souder</u></p>	<p>4. DATE OF DEATH Month Day Year</p> <p><u>3 5 1963</u></p>
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>White</u></p>
<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>1/5/1963</u></p>
<p>9. AGE (last birthday) Months Days Hours Min.</p> <p><u>2</u> <u>2</u> <u>0</u> <u>0</u></p>	<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u></p>
<p>10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u></p>	<p>11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u></p>
<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	<p>13a. FATHER'S NAME <u>Kenneth Souder</u></p>
<p>13b. MOTHER'S MAIDEN NAME <u>Patricia Mosby</u></p>	<p>14. NAME OF HUSBAND OR WIFE <u>-----</u></p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>-----</u></p>	<p>16. SOCIAL SECURITY NO. <u>-----</u></p>
<p>17. INFORMANT <u>Mrs. Kenneth Souder Hallsville, Mo.</u> Address <u>-----</u></p>	<p>18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Acute pneumonitis</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>-----</u></p> <p>DUE TO (c) <u>-----</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>-----</u></p>	<p>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</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>-----</u></p>	
<p>20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year <u>-----</u></p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-----</u></p>
<p>20f. CITY, TOWN, OR LOCATION <u>-----</u> COUNTY <u>-----</u> STATE <u>-----</u></p>	
<p>21. I attended the deceased from <u>Coroner's call</u> and last saw her/him alive on <u>-----</u> Death occurred at <u>6:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Richard E. Johnson, M.D.</u></p>	<p>22b. ADDRESS <u>Columbia, Mo.</u></p>
<p>22c. DATE SIGNED <u>3-5-63</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>3/6/1963</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u></p>	<p>23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u></p>
<p>24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u> ADDRESS <u>Columbia, Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>Mar. 5 1963</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u></p>	

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 David Duffy, Student Embalmer No. 680

working under my personal supervision.

Student

David Duffy  
Signature of Student Embalmer

Signed

Richard A. Reeves

Licensed Embalmer No.

5109

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.