

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011348

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Length of stay in 1b <u>2 days</u>	c. CITY OR TOWN <u>Bethany</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>Noll Hospital</u>		Outside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Noll Hospital</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Walden</u> Last <u>DONNER</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>13</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>3-11-63</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>-</u> Min. <u>-</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Bethany, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Eddie Donner</u>		13b. MOTHER'S MAIDEN NAME <u>Evelyn Hughes</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NO.</u>	17. INFORMANT <u>Eddie Donner - Bethany, Mo.</u>	Address <u>None</u>
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18. CAUSE OF DEATH (Enter only one cause per death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myeloid menbrane bronchi</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</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) <u>Prematurity</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
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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
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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>Bethany, Mo.</u>	COUNTY <u>Mo. Fall</u>	STATE <u>Mo.</u>
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21. I attended the deceased from 3/11/63 to 3/13/63 and last saw him alive on 3/13/63
Death occurred at 10:05 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J.P. Sutherland, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Bethany, Mo</u>	22c. DATE SIGNED <u>3/14/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-15-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mo. Fall</u>	23d. LOCATION (City, town, or county) <u>Mo. Fall Mo.</u>
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24. FUNERAL DIRECTOR <u>H. A. Johnson</u>	ADDRESS <u>Bethany, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-14-63</u>	26. REGISTRAR'S SIGNATURE <u>Zella Masey</u>
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Certificate taken by Doctor 3-14-63 Licensed Practitioner (Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

VS 300 Rev. 4/59

10411

204112

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97735

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

SHOULD READ

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 Henry A. Robinson

Licensed Embalmer No. 5075

P. O. Address Pattonburg, 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.