

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027262

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 517

FILED JUL 29 1963

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Miller	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Length of stay in 1b 2hr. 57min	c. CITY OR TOWN Eldon 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. of Mo. Med. Center		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rt. 2. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Roby Baby Middle Boy Earl Last Shikles			4. DATE OF DEATH Month July Day 20 Year 1963			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-20-63	9. AGE (last birthday) 2 Months 57 Days 57 Hours 57 Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Columbia, Mo.		
13a. FATHER'S NAME James R. Shikles			13b. MOTHER'S MAIDEN NAME Lilah M. Buchanan		12. CITIZEN OF WHAT COUNTRY United States	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi) No		16. SOCIAL SECURITY NO.	17. INFORMANT U. of Mo Medical Record Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 2 hr + 57 min
IMMEDIATE CAUSE (a) Cardio-pulmonary col		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Central nervous system damage		
DUE TO (c) Fetal anoxia		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Uterine rupture		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 6:50 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 **7/20/63** to **7/20/63** and last saw her/him alive on **7/20/63**
Death occurred at **650** A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William Richard O'Rourke MD		22b. ADDRESS U of Mo Med center		22c. DATE SIGNED 7/20/63 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-26-63	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) Columbia	Mo
24. FUNERAL DIRECTOR Robert Johnston		ADDRESS Columbia Mo	25. DATE RECD. BY LOCAL REG. July 26 1963	26. REGISTRAR'S SIGNATURE Mrs RE Padamer

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

1 0109

2 0660

3

4 0

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8 2

9 762.0

10

11

12 2-0

13 3-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____

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.