

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035610

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. 5390 Registrar's No. 90

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 10 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Dent</u>		a. STATE <u>Missouri</u> COUNTY <u>Dent</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Spring Creek Twp.</u>		c. CITY OR TOWN <u>Salem</u>	
Length of stay in 1b		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>Highway "P"</u>		d. STREET ADDRESS (If outside, give location) <u>Rt. 3</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last <u>Esco Junior Tournbaugh</u>			Month Day Year <u>Oct. 5, 1963</u>		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR
<u>Male</u>	<u>White</u>		<u>9/3/1935</u>	<u>28</u>	Months Days Hours Min.
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>Factory Worker</u>				<u>Dent County, Missouri U.S.A.</u>	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE
<u>Esco Tournbaugh</u>			<u>Lola Whitaker</u>		<u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)			16. SOCIAL SECURITY NO.		17. INFORMANT Address
<u>No</u>			<u>43</u>		<u>Esco Tournbaugh, Salem, Missouri</u>

18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Fractures in upper Cervical Region</u>		<u>Immediate</u>
DUE TO (b) <u>Auto Accident</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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.)	
		<u>Auto Accident</u>	
20c. TIME OF INJURY * Hour * Minute * Second		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
<u>9:55 p.m.</u>		<u>Highway P Dent Missouri</u>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
<u>Highway</u>		<u>Highway P Dent Missouri</u>	

21. I attended the deceased from _____, to _____ and last saw her/him alive on Oct. 5, 1963. Death occurred at 9:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED
<u>Paul B. Powell, M.D. Coroner</u>		<u>Salem, Mo.</u>		<u>10-8-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>10/8/1963</u>	<u>North Lawn Cemetery</u>	<u>Salem, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE	
<u>Spencer Funeral Home, Salem, Mo.</u>		<u>10-8-63</u>	<u>M.M. East, M.D. by A.M.</u>	

(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59

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2 0330
3 2
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11 033
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

OCT 11 1963

OCT 15 1963

OCT 14 1963

DEC 12 1963

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 Stephen B. Allison

Licensed Embalmer No. 5181

P. O. Address Salina, 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: