

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037192

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. 5985 Registrar's No. 128

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 1 1963

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood		Length of stay in 1b	c. CITY OR TOWN Fort Leonard Wood
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) US Army Hospital
3. NAME OF DECEASED (Type or print) First ABEL Middle CHAGOYA Last RODRIGUEZ		4. DATE OF DEATH Month September Day 22 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 22 Sep 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY - - -	9. AGE (last birthday) IF UNDER 1 YEAR: Months 2 Days 10 IF UNDER 24 HR: Hours 2 Min 10
11a. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Abel Rodriguez		13b. MOTHER'S MAIDEN NAME Frances Chagoya	14. NAME OF HUSBAND OR WIFE - - -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Abel Rodriguez, Father		Address Co L, 3d Bn, 4th TRS, Ft Leonard Wood, Mo.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY... IMMEDIATE CAUSE (a) Immaturity			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Premature labor, etiology undetermined			
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. N/A <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 3:45 a.m. 3:45 p.m.		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 US Army Hosp, Ft Leonard Wood, Mo	
20g. COUNTY		20h. STATE	
21. I attended the deceased from 22 September 1963 to 22 September 63 and last saw him alive on 22 September 1963 Death occurred at 3:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George Adelson Capt MC		22b. ADDRESS US Army Hosp, Ft Leonard Wood, Mo	22c. DATE SIGNED 23 Sep 63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-25-63	23c. NAME OF CEMETERY OR CREMATORY POST CEMETERY FT. LEONARD WOOD, MO.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR MOSS-WILLIAMS, WAYNESVILLE, MO.		25. DATE RECD. BY LOCAL REG. 9-25-63	26. REGISTRAR'S SIGNATURE <i>George Adelson</i>

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

Clarence Prose

Licensed Embalmer No. 4896

P. O. Address WAYNESVILLE, 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.