

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040970

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 29 1963

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Fort Leonard Wood</b>		c. CITY OR TOWN <b>Ft. Leonard Wood</b>	
Length of stay in 1b <b>17 hours</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>US Army Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>39 Delafield Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>BRYAN</b> Last <b>BAKKEN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Oct 63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11a. FATHER'S NAME <b>Gary Don Bakken</b>		11b. MOTHER'S MAIDEN NAME <b>Glenda Jean Larson</b>	
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 <b>Gary Bakken, 39 Delafield Dr, Ft. Leonard Wood</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO (b) <b>Respiratory distress syndrome (prob. Hyaline membrane)</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) 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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>22 October</b> to <b>23 October</b> and last saw him alive on _____ Death occurred at <b>6:40 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>STEPHEN J. ADELSON, CAPT., MC</b>		22c. DATE SIGNED <b>23 Oct 63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/24/63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>POST CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FT. LEONARD WOOD, MO.</b>	
24. FUNERAL DIRECTOR <b>MOSS-WILLIAMS, WAYNESVILLE</b>		25. DATE RECD. BY LOCAL REG. <b>10-23-63</b>	
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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**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 Foose

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.