

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0047516

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 147 FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Buchanan</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>6 hrs 24 Min</u>	c. CITY OR TOWN <u>Amazonia</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Methodist Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. R. #1</u>
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <u>DONNA</u> Middle <u>MARIE</u> Last <u>CRIPPEN</u>			Month <u>December</u> Day <u>29</u> Year <u>1964</u>
5. SEX <u>Female</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>12/29/1964</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>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months <u>—</u> Days <u>—</u> Hours <u>6</u> Min. <u>24</u>
11a. BIRTHPLACE (City and state or country) <u>St. Joseph Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Marvin S. Crippen</u>		13b. MOTHER'S MAIDEN NAME <u>Vina Darlene Welter</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>None</u>		17. INFORMANT <u>Mr. Marvin S. Crippen Amazonia, Mo.</u>	
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
IMMEDIATE CAUSE (a) <u>Prematurity (28 weeks)</u>			<u>6 hours</u>
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)			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 _____ 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 <u>12-29-64</u> to <u>12-29-64</u> and last saw her <u>xxx</u> alive on <u>12-29-64</u>			
Death occurred at <u>7:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Warren Baker MD</u>		22b. ADDRESS <u>Savannah, Missouri</u>	22c. DATE SIGNED <u>12-30-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem & Burial</u>	23b. DATE <u>12/30/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Savannah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Savannah Missouri</u>
24. FUNERAL DIRECTOR <u>Stacy Turner Home</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 4, 1965</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>
ADDRESS <u>St. Joseph, Mo.</u>			

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF W.C. Baker, MD MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

Permit issued 12-29-64

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph 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.