I, being 18 years or older, hereby contribute my body following death, to the Department of Pathology and Anatomical Sciences, School of Medicine, University of Missouri, Columbia, Missouri for educational, scientific or such purposes as the authorized personnel of said University shall in their sole discretion deem proper. I hereby direct that my unautopsied and unembalmed body be delivered to said Department of Pathology and Anatomical Sciences at Columbia, Missouri as soon after death as possible.

Date     Signature of Donor

Date     Signature of Witness

Date     Signature of Witness
INFORMATION NEEDED FOR MISSOURI CERTIFICATE OF DEATH

1. Birthplace (city and state, or foreign country): __________________________

2. Date of Birth: _________ Social Security Number: _______________________

3. Ever in U.S. Armed Forces (yes or no): ______________________

4. Martial Status (married, never married, widowed, divorced): ______________

5. Surviving Spouse’s Name (if wife, give her full maiden name):

    First                  Middle                  Last

6. Usual Occupation (during most of working life; do not used retired): _________

7. Kind of Business or Industry: ________________________________

8. Residence: State: _______________ County: __________________________

    City, Town, or Location: ________________________________

    Street and Number: __________________________ Zip Code: _________

    Inside City Limits (yes or no): _________________________

    Years at Present Address: Under 5: _______________

        5 to 9: _______________________

        10 to 19: _____________________

        20 or more: ____________________

9. Of Hispanic Origin (yes or no- if yes, specify, Cuban, Mexican, Puerto Rican, etc.):

    ______________________________

10. Race (American Indian, White, Black, etc.): ____________________________

11. Years of Education: Elementary (secondary 0-12): _______________________

    College (1-5 or 5+): _______________________

12. Father’s Name:

    First                  Middle                  Last

13. Mother’s Name:

    First                  Middle                  (Maiden)                  Last

    (Please Print)

The above information will remain confidential and will be used only at the discretion of the Department of Pathology and Anatomical Sciences.
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<thead>
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<tbody>
<tr>
<td>1.</td>
<td>Name: ____________________________ First Middle Last</td>
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<td>2.</td>
<td>Date this Form was Complete: _________________________________</td>
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<td>3.</td>
<td>Sex: ______________________________</td>
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<td>4.</td>
<td>Date of Birth: ____________________________ Month Day Year</td>
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<td>5.</td>
<td>Congenital (inborn) Abnormalities: ______________________________</td>
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<td>6.</td>
<td>Abnormalities Acquired Through Injury or Disease: ________________</td>
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<td>7.</td>
<td>Major Surgeries and Approximate Dates: __________________________</td>
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<td>8.</td>
<td>Present State of Health: _____________________________________</td>
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<td>9.</td>
<td>Additional Information Relating to Physical Condition: ____________</td>
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