GIFT OF BODY

NAME (PLEASE PRINT)

STREET ADDRESS

CITY, STATE, ZIP CODE

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

The above information will remain confidential and will be used only at the discretion of the Department of Pathology and Anatomical Sciences.

_____ _____
First Middle Last Date
(Please Print)

BRIEF MEDICAL HISTORY

1. Name: _____
   First Middle Last

2. Date this Form was Complete: _____

3. Sex: _____

4. Date of Birth: _____
   Month Day Year

5. Congenital (inborn) Abnormalities: _____

   _____

6. Abnormalities Acquired Through Injury or Disease: _____

   _____

7. Major Surgeries and Approximate Dates: _____

   _____

   _____

   _____

   _____

8. Present State of Health: _____

9. Additional Information Relating to Physical Condition: _____

   _____

   _____

   _____