

FILED AUG 9 - 1955 STANDARD CERTIFICATE OF DEATH

State File No. 25022

BIRTH NO. 34438-55 REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 6152 Registrar's No. 66

1030
0

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dexter Liberty Twp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (Castor)	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) R.F. D. #3, Dexter, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Sam Davis Hospital			

3. NAME OF DECEASED (Type or Print) Linda		a. (First) b. (Middle) Diane c. (Last) Clampitt		4. DATE OF DEATH (Month) (Day) (Year) July 28, 1955	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	
8. DATE OF BIRTH June 13, 1955		9. AGE (In years last birthday) 0		10. MONTHS 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Allenville, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Clifford Lacy		13b. MOTHER'S MAIDEN NAME Goldie Ramsey		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Clifford Lacy, Dexter, Mo. R. 3	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days	

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lactose bowel</u>		DUE TO (b) <u>Curled meats</u>		DUE TO (c)	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		5705	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7-27-1955 to 7-28-1955, that I last saw the deceased alive on 7-28-1955, and that death occurred at 12:50 pm, from the causes and on the date stated above.

23a. SIGNATURE S. S. Davis, M.D.		23b. ADDRESS Dexter, Mo.		23c. DATE SIGNED 8-2-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-30-55		24c. NAME OF CEMETERY OR CREMATORY Fairview	
24d. LOCATION (City, town, or county) (State) R.F.D. Delta, Mo.					

DATE RECD BY LOCAL REG. 8/5/55		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Strickland-Rainey	
				ADDRESS Dexter, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Lucille Rainey

Student Embalmer No. 508

working under my personal supervision.

Student *Lucille Rainey*
Student Embalmer

Signed *J. J. [Signature]*
Licensed Embalmer No. 3479
P. O. Address *Watts, 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 this body is not embalmed, fact should be so stated above.