

Health,
Welfare
Public
Service

300
-56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 14 1957

31186

STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 120

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LIBERTY 5</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>EXCELSIOR SPRINGS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>I.O.O.F. HOME</u>			Length of stay in 1b <u>9 1/2 mos.</u>	d. STREET ADDRESS (If outside, give location) <u>410 E. BROADWAY</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LYDIA</u> Middle <u></u> Last <u>FREEZE</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-1880</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></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>		11. BIRTHPLACE (City and state of country) <u>RAYVILLE, Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</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>JOE COX</u> Address <u>201 HAYNES EXCELSIOR SPRINGS, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <u>4500</u>						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.) <u>4500</u>				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____							
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>1940</u> to <u>Sept 23 1957</u> and last saw her alive on <u>Sept 23</u> Death occurred at <u>10 A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Wm. J. Jackson M.D.</u>				22b. ADDRESS <u>Liberty, Mo.</u>		22c. DATE SIGNED <u>9/25/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>9-24-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHAWNEE CEMETERY</u>		23d. LOCATION (City, town, or county) <u>SHAWNEE KANSAS</u>		(State)
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>10-5-57</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u>		

(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 em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lindell Jarman*.....

Licensed Embalmer No. *45*
Excelsior Springs
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.