

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036947

STATE FILE NUMBER

FILED OCT 16 1958

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 140

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY LACLEDE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LACLEDE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LEBANON		c. CITY OR TOWN MORGAN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WALLACE HOSPITAL		d. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) First SYLVANIA Middle C Last CLIMER		4. DATE OF DEATH Month OCTOBER Day 3 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) WRIGHT CO., MISSOURI
13a. FATHER'S NAME FRANK WALKER		13b. MOTHER'S MAIDEN NAME MILLIE JONES	14. NAME OF HUSBAND OR WIFE ELMER CLIMER
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. —	17. INFORMANT Address ELMER CLIMER MORGAN, MISSOURI
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure			INTERVAL BETWEEN ONSET AND DEATH 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) diabetes Coma			12 hrs
DUE TO (c) diabetes mellitus			4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 11/15/51 to 10/3/58 and last saw her alive on 10/3/58 Death occurred at 6 AM on the date stated above; and to the best of my knowledge/ from the causes stated.			
22a. SIGNATURE James D. Howe, M.D. (Type or print)		22b. ADDRESS Lebanon, Mo	22c. DATE SIGNED 10/4/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	OCT 5 1958	ROPER CEMETERY	LACLEDE CO MISSOURI
24. FUNERAL DIRECTOR ADDRESS DORSEY M HOWE LEBANON, MISSOURI		25. DATE RECD. BY LOCAL REG. 10-4-1958	26. REGISTRAR'S SIGNATURE Hella L. Gray

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Received OCT 14 1958

Laclede County Health Unit

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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 Dorsey M. Howe

Licensed Embalmer No. 4222
P. O. Address Lebanon

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.