

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001919
STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. 170 Primary Registration District No. Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon - RURAL</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Lebanon</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home - Rt. #5</u> Length of stay in lb <u>4 years</u>		d. STREET ADDRESS (If outside, give location) <u>Lebanon Rt #5</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Moulder</u> Last <u>Thomas</u>			4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1959</u>		
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5. SEX <u>Male</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>March 26, 1881</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>5</u> Min.	IF UNDER 24 HRS. Hours <u>5</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Linn Creek, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Thomas</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Huddleston</u>	14. NAME OF HUSBAND OR WIFE <u>—</u>
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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>Mrs Eden Potter</u> Address <u>Lockwood, Missouri</u>
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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>cerebrovascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one month</u>
DUE TO (b) <u>generalized arteriosclerosis</u>		
DUE TO (c) <u>—</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331x</u>		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input checked="" 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.)
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20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	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 <u>Lebanon, Mo</u> COUNTY <u>Camden</u> STATE <u>Missouri</u>
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21. I attended the deceased from <u>1/8/59</u> to <u>1/28/59</u> and last saw him alive on <u>1/13/59</u> Death occurred at <u>4:05 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Dorsey E. Fisher M.D.</u> (Degree or title)	22b. ADDRESS <u>Lebanon, Mo</u>	22c. DATE SIGNED <u>1/26/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 26, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Decaturville Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Camden County, Missouri</u>
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24. FUNERAL DIRECTOR <u>Dorsey Howe Lebanon, Mo.</u> ADDRESS <u>Lebanon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-26-1959</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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.