

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018000

FILED VS MAY 2 1960

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 88 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>-----</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>54 yrs.</u>	c. CITY OR TOWN <u>St Louis</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>Marshall State School and Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3615 N. 22nd St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>---</u> Last <u>Uckley</u>			4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-1893</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	IF UNDER 24 HR Hours <u>---</u> Min. <u>---</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patient</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>William Uckley</u>	13b. MOTHER'S MAIDEN NAME <u>"Freida" Schweitzer</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>Records Marshall State School & Hospital Marshall, Mo.</u> Address
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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>Broncho-pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
DUE TO (b) <u>Arterio-sclerotic heart disease</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>Congenital imbecile</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u>---</u> Month, Day, Year <u>---</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from <u>April 1, 1958</u> to <u>Apr. 27 1960</u> and last saw her/him alive on <u>4-27-1960</u> Death occurred at <u>8:30 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>W. B. Day</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Marshall State School & Hosp. Marshall Mo.</u>	22c. DATE SIGNED <u>4-28-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Marshall Missouri</u>
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24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4-28-60</u>	26. REGISTRARS SIGNATURE <u>Cecil G. Reed</u>
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DOCUMENT

MEDICAL CERTIFICATION

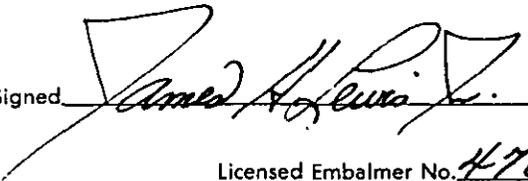
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4709

P. O. Address Marshall

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.