

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 16 1960

=60-022599

STATE FILE NUMBER

Registration District No. 11 Primary Registration District No. 3012 Registrar's No. 62

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) <u>Excelsior Springs</u>		c. CITY OR TOWN <u>Excelsior Springs</u>	
Length of stay in 1b <u>12 yrs.</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>510 Caldwell St.</u>		d. STREET ADDRESS (If outside, give location) <u>510 Caldwell</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Eldon</u> Middle <u>Douglas</u> Last <u>Douglas</u>			4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-1901</u>	9. AGE (last birthday) <u>58</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>Engineer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>	11. BIRTHPLACE (City and state or country) <u>Caldwell County</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>J. M. Douglas</u>	13b. MOTHER'S MAIDEN NAME <u>Georgia Lee Traut</u>	14. NAME OF HUSBAND OR WIFE <u>Lorene Rowland</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>487-07-0651</u>	17. INFORMANT <u>Mrs. Lorene Douglas, Excelsior Springs Mo.</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>Ca. of Larynx metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ a.m. _____ p.m. Month, Day, Year _____
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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 5-5-59 to 6-3-60 and last saw <sup>her</sup>him alive on 6-3-60  
Death occurred at 12:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>George E Sanders MD</u>	22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>6-6-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-5-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawson</u>	23d. LOCATION (City, town, or county) (State) <u>Lawson, Missouri</u>
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24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u>	25. DATE RECD. BY LOCAL REG. <u>6-6-60</u>	26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lundee Jarnard

Licensed Embalmer No. 458

P. O. Address Excelsior Springs

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.