

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046673

FILED VS JAN 4 1961
INDEXED

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 194

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <i>Laclede</i>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Lebanon</i>		c. CITY OR TOWN <i>Lebanon</i>		d. STREET ADDRESS (If outside, give location) <i>412 S. Jackson St.</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>8/12/1888</i>		9. AGE (last birthday) <i>72</i>		IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Dixon Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Russ Labors</i>		13b. MOTHER'S MAIDEN NAME <i>unknown</i>		14. NAME OF HUSBAND OR WIFE <i>Amos</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>494-03-9020B</i>		17. INFORMANT <i>Bert Groves Hartford City Ind.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>undetermined (accumulation of gas in stomach)</i>						?	
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) <i>Physician - for years, died in sleep</i>						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	
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			
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 _____ to _____ and last saw him alive on _____ Death occurred at <i>1:00 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Hella L. Hays, Local Registrar</i>				22b. ADDRESS <i>Lebanon, Missouri</i>		22c. DATE SIGNED <i>12-27-1960</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/27/1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grange Hall Cemetery near Lebanon, Mo.</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <i>Dorsey M. Howe Lebanon, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>12-27-1960</i>		26. REGISTRAR'S SIGNATURE <i>Hella L. Hays</i>	

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 Dorsey M. How

Licensed Embalmer No. 422

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.