

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002004

FILED VS FEB 7 1961 170

Registration District No. \_\_\_\_\_ Primary Registration District No. 3033 Registrar's No. 21

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Laclede</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lebanon</b>		Length of stay in lb <b>10 Yrs.</b>	c. CITY OR TOWN <b>Lebanon</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>446 Hough St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>446 Hough St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>JOHN RAYMOND CAUFIELD</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>26</b> , Year <b>1961</b>		
---	--	--	---	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-30-96</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Booker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Beverage</b>	11. BIRTHPLACE (City and state or country) <b>Laclede County Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
--	--	---	---

13a. FATHER'S NAME <b>John Caufield</b>	13b. MOTHER'S MAIDEN NAME <b>Bessie Wolfe</b>	14. NAME OF HUSBAND OR WIFE <b>Elsie Caufield</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, of unknown) (If yes, give dates of service) <b>Yes one</b>	16. SOCIAL SECURITY NO. <b>111-11-1111</b>	17. INFORMANT Address <b>Mrs. Elsie Caufield, Lebanon, Mo.</b>
--	---	--

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) <b>acute myocardial infarction</b>		<b>5 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerosis, generalized</b>	<b>3 yrs.</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) <b>① Pulmonary tbc, rt. apex, inactive ② osteo arthritis of spine</b>	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
--	--

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 _____ a.m. _____ p.m. 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 <b>7-17-56</b> to <b>1-26-61</b> and last saw <sup>her</sup> him alive on <b>7-26-1961</b> Death occurred at <b>3:30 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>B. H. Hurst, M.D.</b>	22b. ADDRESS <b>Lebanon, Mo.</b>	22c. DATE SIGNED <b>1-27-61</b>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>1-30-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lebanon, Mo.</b>
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>D. R. Palmer</b>	ADDRESS <b>Lebanon Mo</b>	25. DATE RECD. BY LOCAL REG. <b>1-30-1961</b>	26. REGISTRAR'S SIGNATURE <b>Hella L. Day</b>
---	------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

FEB 7 1961

**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 S. R. Palmis

Licensed Embalmer No. 2208

P. O. Address Lebanon mo

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.