

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005897

STATE FILE NUMBER

Registration District No. B06 Primary Registration District No. 3042 Registrar's No. 7

FILED VS FEB 28 1961

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

3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>IDA</u> Last <u>WARD</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>FEMALE</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>3-14-1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>CLUBB, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>SIDNEY J. BURCH</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET PATE</u>		14. NAME OF HUSBAND OR WIFE <u>CLARDY WARD</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>CLARDY WARD</u> Address <u>FREDRICKTOWN, MO.</u>		

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>Myocardial Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last. DUE TO (b) <u>Pneumonia Lobar</u>		
DUE TO (c) <u>Arterio Sclerosis (marked)</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>This lady has had a paralytic stroke 4 years ago from which she never recovered.</u>		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.)	
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
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21. I attended the deceased from _____ to Jan 14 1961 and last saw her/him alive on Jan 12 1961
Death occurred at Home 407 Belmont 11:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. C. Slaughter, M.D.</u> (Degree or title)	22b. ADDRESS <u>135 W. Main Fredricktown Mo</u>	22c. DATE SIGNED <u>2-17-61</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-16-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW HOME</u>	23d. LOCATION (City, town, or county) (State) <u>CLUBB MO</u>
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24. FUNERAL DIRECTOR <u>GISH FUNERAL HOME</u> ADDRESS <u>GREENVILLE, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>2-21-1961</u>	26. REGISTRAR'S SIGNATURE <u>Frederick Dickel</u>
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AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD-READ
 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 me,
or by me, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marvin E. Bowler

Licensed Embalmer No. 4426

P. O. Address Piedmont, N.C.

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.