

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018151

AMENDED

Registration District No. 176 Primary Registration District No. 5-637 Registrar's No. 10

STATE FILE NUMBER

FILED JUN 12 1961

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sarcoux RR-1 Red Oak</u>		Length of stay in 1b	c. CITY OR TOWN <u>Sarcoux</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <u>R.F. Dr. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>W.</u> Last <u>Pickens</u>			4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1961</u>		
5. SEX <u>Male</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>1-11-1891</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u>
IF UNDER 24 HR Hours <u></u> Min. <u></u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Van Alstyne Texas</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	13a. FATHER'S NAME <u>Donald Weir Pickens</u>		13b. MOTHER'S MAIDEN NAME <u>Sabbie Loronia Stahl</u>		14. NAME OF HUSBAND OR WIFE <u></u>
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>Mr. Greer Pickens</u>		Address <u>Sarcoux RR-1</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>Ventricular Fibrillation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <u>Coronary Myocardial Infarction</u>
DUE TO (c) <u>Coronary Arteriosclerotic Heart Disease</u>					<u>10 days</u>
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
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <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
21. I attended the deceased from <u>May 21, 1961</u> to <u>May 31, 1961</u> and last saw him alive on <u>May 31, 1961</u> Death occurred at <u>6:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Raymond A. Carlson MD</u>			22b. ADDRESS <u>403 Main St. Salem City, Mo</u>		22c. DATE SIGNED <u>6-3-61</u>
23a. BURIAL, CREMATION, REPOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>6-3-1961</u>	<u>Arifika</u>		<u>N. of Arifika Mo.</u>	
24. FUNERAL DIRECTOR <u>Morris - Leman</u>		ADDRESS <u>Miller Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-4-61</u>	26. REGISTRAR'S SIGNATURE <u>D. J. Bussney</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JUN 16 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

L. H. Seiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.