

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025825

STATE FILE NUMBER

AMENDED

Registration District No. 171 Primary Registration District No. 5638 Registrar's No. 22

FILED JUL 27 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Lafayette</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sniabar Twns</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Lafayette</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 Mi. SW of Odessa</u>		Length of stay in 1b <u>40 Yrs.</u>		c. CITY OR TOWN <u>Naer Odessa</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>3 Mi. SW of Odessa</u>		(If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Erma</u>		Middle <u>E.</u>		Last <u>Gott</u>		Month <u>July</u> Day <u>23</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>7-4-05</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
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		11. BIRTHPLACE (City and state or country) <u>Lafayette Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>John Allison</u>			13b. MOTHER'S MAIDEN NAME <u>Lena Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>Cliff Gott</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>Cliff Gott, Odessa, Mo.</u>			
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) <u>Inanition</u>						<u>3 weeks</u>	
DUE TO (b) <u>Carcinoma of Stomach</u>						<u>4 months</u>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Alimentary Arthritis</u>						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"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20e. TIME OF INJURY Hour a.m. p.m.	20f. MONTH, DAY, YEAR						
20g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>	20h. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20i. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>March 1956</u> to <u>July 14, 1961</u> and last saw her alive on <u>July 14, 1961</u> Death occurred at <u>July 23, 1961 6:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Charles L. Cooper M.D.</u>				22b. ADDRESS <u>618 Professional Bldg. K.C. Mo.</u>		22c. DATE SIGNED <u>7-24-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 25, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Odessa, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Husman-Sparks, Odessa, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>July 27, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. 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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William T. Sparks

Licensed Embalmer No. H 431

P. O. Address Odessa, Va

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.