

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025893

STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 95

FILED JUL 17 1961

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Braskfield</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>Laclede</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mc. Larkney Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>none</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>LENORA MAY CAYWOOD</u>			4. DATE OF DEATH Month Day Year <u>July 10, 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/878</u>	9. AGE (last birthday) <u>82</u> Months <u>9</u> Days <u>9</u> Hours <u></u> Min. <u></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>in own home</u>		11. BIRTHPLACE (City and state or country) <u>Braskfield, Mo.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Isaac Bigger</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen (unknown)</u>		
14. NAME OF HUSBAND OR WIFE <u>Albert J. Caywood (deceased)</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>Florence Fisher, Braskfield, 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>Cerebral vascular accident.</u> DUE TO (b) <u>Hypertensive cardiac vascular disease.</u> DUE TO (c) <u>Generalized arteriosclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Adenocarcinoma of bladder - urinary</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 INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>		

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.) <u>-</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>-</u>		Month, Day, Year <u>-</u>		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.) <u>-</u>		20f. CITY, TOWN, OR LOCATION <u>-</u>		COUNTY <u>-</u> STATE <u>-</u>	

21. I attended the deceased from June 13 61 to July 10 61 and last saw her/him alive on July 10, 1961
Death occurred at - m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. W. Burkhardt M.D.</u>		22b. ADDRESS <u>Braskfield Mo.</u>		22c. DATE SIGNED <u>7/11/61.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laclede Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Laclede, Missouri</u>		23e. STATE <u>Missouri</u>		24. FUNERAL DIRECTOR <u>Nile Funeral Home, Braskfield, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>6-14-61</u>		26. REGISTRAR'S SIGNATURE <u>Walter Brown</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Ag 29

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

Ronald F. Webb

Licensed Embalmer No. 417

P. O. Address Brown

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to copy 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.