

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=61-036252**

STATE FILE NUMBER

AMENDED

Registration District No. 10

Primary Registration District No. \_\_\_\_\_

Registrar's No. 51

**FILED OCT 24 1961**

1. PLACE OF DEATH a. COUNTY <u>Clark</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clark</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kahoka</u>		Length of stay in 1b	c. CITY OR TOWN <u>Kahoka</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>Dunn Nursing Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>167 W. Elm</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>Roxena</u> Last <u>Prickett</u>			4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1961</u>		
5. SEX <u>Female</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>2-27-1884</u>	9. AGE (last birthday) <u>77</u>
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Clark County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Prickett</u>		13b. MOTHER'S MAIDEN NAME <u>Georgiana Sherwood</u>		14. NAME OF HUSBAND OR WIFE <u>Mr. Lloyd Spencer</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.	17. INFORMANT <u>Mr. Lloyd Spencer</u> Address <u>Kahoka, Missouri</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>Medullary failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
DUE TO (b) <u>Cerebral anoxia and infarction</u>					<u>2 Weeks</u>
DUE TO (c) <u>Arteriosclerosis</u>					<u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia</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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>11-3-58</u> to <u>9-24-61</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>9-24-61</u> Death occurred at <u>2 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. L. Shaffer</u> (Degree or title)			22b. ADDRESS <u>Kahoka, Missouri</u>		22c. DATE SIGNED <u>9-30-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-26-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kahoka City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kahoka, Missouri</u>	
24. FUNERAL DIRECTOR <u>D. L. Shaffer</u> ADDRESS <u>Kahoka, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>10-21-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

(Licensed Embelmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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  \_\_\_\_\_

Licensed Embalmer No. 5063

P. O. Address Wabasha, 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.