

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037536

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 86

AMENDED

FILED NOV 10 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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) <u>Lexington</u>		STATE <u>Missouri</u>		COUNTY <u>Lafayette</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lexington Memorial Hosp</u>		Length of stay in lb <u>2 Mo.</u>		c. CITY OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>1723 Oneida</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frieda</u> Middle <u>Cecil</u> Last <u>June</u>				4. DATE OF DEATH Month <u>October</u> Day <u>26</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6, 1888</u>	
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garment Making</u>		11. BIRTHPLACE (City and state or country) <u>Lexington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Wm Fischer</u>			13b. MOTHER'S MAIDEN NAME <u>Agatha Willig</u>			14. NAME OF HUSBAND OR WIFE <u>Joseph Cecil</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>				17. INFORMANT <u>Mrs. Richard Davis</u> Address <u>Miama Fla.</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>Hepatic failure</u>						<u>2 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Carcinoma of liver</u>	
DUE TO (c) <u> </u>						<u>1 yr.</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> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>9-26-61</u> to <u>10-26-61</u> and last saw her/him alive on <u>10, 26, 61</u> Death occurred at <u>4:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Ralph A. G. [Signature]</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>Lexington, Mo</u>		22c. DATE SIGNED <u>10.30.61</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		23d. LOCATION (City, town, or county) <u>Lexington, Mo</u> (State)	
24. FUNERAL DIRECTOR <u>Vaughn-Walker</u> ADDRESS <u>Lexington, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>30 Oct. 1961</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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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 W. R. Vaughan

Licensed Embalmer No. 4023

P. O. Address Sevington, Md

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.