

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037667

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 178

FILED OCT 16 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>LIVINGSTON</u>		a. STATE <u>MO.</u>	b. COUNTY <u>LIVINGSTON</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CHILLICOTHE</u>	Length of stay in 1b <u>1 WEEK</u>	c. CITY OR TOWN <u>CHILLICOTHE</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>CITY HOSPITAL</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 E. JACKSON ST.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>CLEONA</u>	Middle <u>DARLE</u>	Last <u>STICK</u>	4. DATE OF DEATH	Month <u>SEPTEMBER</u>	Day <u>30</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>4/11/1919</u>	9. AGE (last birthday) <u>42</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
----------------------	-------------------------------	---	-----------------------------------	----------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>GRAVITY, IOWA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
---	--	---	--

13a. FATHER'S NAME <u>PEARL Mc COWN</u>	13b. MOTHER'S MAIDEN NAME <u>EVA EULLA CLARK</u>	14. NAME OF HUSBAND OR WIFE <u>HAROLD STICK</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 Address <u>HAROLD STICK: CHILLICOTHE, MISSOURI</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 <u>12 hrs.</u> <u>36 hrs.</u> <u>1 wk.</u>
IMMEDIATE CAUSE (a) <u>Shock</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Rt. heart failure</u>	
	DUE TO (c) <u>Asthma Severe</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	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>July 1, 61</u> to <u>Sept. 30, 61</u> and last saw him/her alive on <u>Sept. 30, 61</u>
Death occurred at <u>1:00</u> P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph A. Conrad M.D.</u>	22b. ADDRESS <u>Chillicothe, MO</u>	22c. DATE SIGNED <u>Oct. 4 '61</u>
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>AVALON CEMETERY</u>	23d. LOCATION (City, town, or county) <u>AVALON, MISSOURI</u>
---	--------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>NORMAN FUNERAL HOME: Chillicothe, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 2, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>
---	---	---

DATE AMENDED

INSTEAD OF DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

OCT 31 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 Elton Doiman

Licensed Embalmer No. 4036

P. O. Address CHILLICOTHE, MIS

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.