

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-042035

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 74 Primary Registration District No. 4135 Registrar's No. 47

STATE FILE NUMBER

FILED NOV 29 1962

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gower Mo</u>		Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>Gower</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clearview Addition</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 Mi East of Gower</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>OLA MAY RADECK</u>			4. DATE OF DEATH Month Day Year <u>Nov. 26 1962</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1882</u>
9. AGE (last birthday) <u>80</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	11. BIRTHPLACE (City and state or country) <u>Martinsville, Ind.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>James M. Huffman</u>	
13b. MOTHER'S MAIDEN NAME <u>Lanora Avery</u>		14. NAME OF HUSBAND OR WIFE <u>George B. Radeck</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>Arthur Huffman</u> Address <u>Gower 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>Acute Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
DUE TO (b) <u>Acute Coronary Occlusion</u>			<u>5 days</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>Acute Influenza -</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <u>7 days.</u> <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 a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>4-4-61</u> to <u>11-26-62</u> and last saw her alive on <u>11-26-62</u> Death occurred at <u>1:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John P. Maloney M.D.</u>		22b. ADDRESS <u>Plattsburg Mo.</u>	22c. DATE SIGNED <u>11-26-62</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 28, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>	23d. LOCATION (City, town, or county) <u>Gower Mo.</u>
24. FUNERAL DIRECTOR <u>Clarence E. Hinson - Gower Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-26-62</u>	26. REGISTRAR'S SIGNATURE <u>Mary W. Searee</u>	

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
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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 Clarence E. Gibson

Licensed Embalmer No. 5122

P. O. Address. Gower, 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.