

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039263

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 70 Primary Registration District No. 4124 Registrar's No. 58

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 17 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Clark</u>		a. STATE <u>Mo.</u> b. COUNTY <u>Clark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kahoka</u>		c. CITY OR TOWN <u>Kahoka, Mo.</u>	
Length of stay in 1b		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>Mitchel Rest Home</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Allie Middle McLaughlin Last</u>			4. DATE OF DEATH <u>Month Oct, Day 1, Year 1963</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>11-25-1881</u>
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR	IF UNDER 24 HR
		Months	Days
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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Ainsworth Iowa</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>David Edmondson</u>	
13b. MOTHER'S MAIDEN NAME <u>Susan - Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>James McLaughlin</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. [REDACTED]	
17. INFORMANT <u>Mr. Dave McLaughlin, Kahoka, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Medullary fracture</u>			<u>10 hrs.</u>
DUE TO (b) <u>Cerebral thrombosis and encephalomalacia 3 days</u>			
DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia</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 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.	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>1-11-59</u> to <u>9-30-63</u> and last saw her ^{him} alive on <u>9-30-63</u>			
Death occurred at <u>3:20 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. L. Willard</u>		22b. ADDRESS <u>Kahoka Mo</u>	22c. DATE SIGNED <u>10-14-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 3, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kahoka Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kahoka, Mo.</u>
24. FUNERAL DIRECTOR <u>Karl Shaffer Funeral Home, Kahoka, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 15, 1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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. 5867

P. O. Address Wichita, 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.