No. 300
10-48

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16431

State File No. 6-49-69

BIRTH NO. 29153-49 REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 83

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY: Laclede
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lebanon 0
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Louise G Wallace

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Laclede 53
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Conway 0
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): SHARRON
b. (Middle): KAY
c. (Last): LAYMAN

4. DATE OF DEATH (Month) 5 (Day) 27 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: 5-26-1949
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 6 Days; IF UNDER 24 HRS. Hours 24 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri 0
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Lloyd LAYMAN
13b. MOTHER'S MAIDEN NAME: DOROTHY RUBLE
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Lloyd Layman
ADDRESS: CONWAY

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature birth 6 mo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 776X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-26, 1949, *to* 5-27, 1949 *that I last saw the deceased alive on* 5-26, 1949 *and that death occurred at* 9 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J W Lindsay MD
23b. ADDRESS: Conway Mo
23c. DATE SIGNED: 6-1-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE:
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: June 1-1949
REGISTRAR'S SIGNATURE: Della L. Day 424
25. FUNERAL DIRECTOR'S SIGNATURE: none
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

Received JUN 4 1949
Laclede County Health Unit
File No. 6-X-9-69
Date Filed JUN 6 1949

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 .....
Student Embalmer

no licensed director

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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 this body is not embalmed, fact should be so stated above.