

FILED AUG 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25946**

BIRTH NO.		REG. DIST. NO. <u>1</u>	PRIMARY REG. DIST. NO. <u>3000</u>	Registrar's No. <u>239</u>
1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>		
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>Kirksville</b>		c. LENGTH OF STAY (in this place) <b>30 years</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>Kirksville</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Laughlin Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>1418 South First St.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>CORA</b>		b. (Middle) <b>WHITEFORD</b>	c. (Last) <b>ARCHER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>August 8, 1949</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 8, 1870</b>	9. AGE (In years last birthday) <b>78</b> IF UNDER 1 YEAR Months <b>8</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home making</b>	11. BIRTHPLACE (State or foreign country) <b>Stark Co., Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>James Whiteford</b>		13b. MOTHER'S MAIDEN NAME <b>Orpha Kendrick</b>	14. NAME OF HUSBAND OR WIFE <b>John W. Archer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <b>Ray Archer, South Gate, Calif.</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Diffuse abdominal carcinomatosis of undetermined origin</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>Undetermined</b> DUE TO (c) <b>Undetermined</b> II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>  <b>1948</b>
19a. DATE OF OPERATION <b>8-5-49</b>	19b. MAJOR FINDINGS OF OPERATION <b>Biopsy of multiple "nodules" of entire gut and peritoneal surfaces (cancer)</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR		
22. I hereby certify that I attended the deceased from <b>8-2-49</b> , 19___, to <b>8-8-49</b> , 19___; that I last saw the deceased alive on <b>8-7-49</b> , 19___, and that death occurred at <b>1:40 An.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>Carl Laughlin Jr</b>		23b. ADDRESS <b>D.O.2 - Kirksville, Mo.</b>	23c. DATE SIGNED <b>8-12-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8-10-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>La Plata Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>La Plata, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>8-13-49</b>	REGISTRAR'S SIGNATURE <b>Mate Lambert</b>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Davis Funeral Home, Kirksville, Mo.</b>		

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

RECEIVED AUG 22 1949  
District Health Officer No. 10  
District File Number 8-49-146  
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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, only

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Clarence M. Bills

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4375

P. O. Address Keokuk, 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 this body is not embalmed, fact should be so stated above.