

FILED APR 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

5-42  
0

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Lexington</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lexington</u>	
c. LENGTH OF STAY (in this place) <u>2 days</u>		d. STREET ADDRESS (If rural, give location) <u>Irish Town, Hill</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hosp.</u>			

054  
0

3. NAME OF DECEASED (Type or Print) a. (First) <u>PETER</u> b. (Middle) <u>CLARICO</u> c. (Last) <u>CLARICO</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 14, 1950</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Oct. 27, 1868</u>		9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Not Known</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE <u>Maddelina Ollaro</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not Known</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Paul Clarico, Lexington, Mo.</u>	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>2nd &amp; 3rd degree venous disease of stametes</u>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		<u>2.9/50</u>	
				DUE TO (c)		<u>16</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>n54</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident Home</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Lexington Lafayette Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>13 April 50 3 P.M.</u>		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>While bending grass</u>	

22. I hereby certify that I attended the deceased from April 13 50 to 14 April, 1950, that I last saw the deceased alive on 14 April, 1950, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)		23b. ADDRESS <u>Lexington Mo</u>		23c. DATE SIGNED <u>4/14/50</u>	
---	--	----------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/15/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Lexington, Mo.</u>	
---	--	--------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. <u>April 24, 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		GENERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Lexington Mo</u>	
--	--	--	--	---	--	-----------------------------	--

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

RECEIVED

APR 27

District Health Officer No. 8.

District File Number

4-28-50

Date Filed

MAY 1950

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

Signed

*L. J. McKeane*

Licensed Embalmer No.

2983

P. O. Address

*Belmont, Mass*

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.