No. 300
10.48

FILED SEP 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27434

BIRTH NO. _____ REG. DIST. NO. 180 PRIMARY REG. DIST. NO. 4290 Registrar's No. 11

0570

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

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Foley
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): Daughters home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Foley 0570
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): Henry
c. (Last): Luckett

4. DATE OF DEATH (Month) (Day) (Year): Aug. 8, 1950

5. SEX: male 0
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed (twice) 2
8. DATE OF BIRTH: Oct. 3, 1869
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

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

13a. FATHER'S NAME: Frank Luckett
13b. MOTHER'S MAIDEN NAME: Nancy Garner
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): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: McKinley Murphy - Foley, Mo.

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) Arteriosclerotic heart disease

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

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: 4200

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* 7-10, 1950, *to* 8-8, 1950, *that I last saw the deceased alive on* 8-8, 1950, *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert N Hill M.D.
23b. ADDRESS: Elsberry, Mo.
23c. DATE SIGNED: 8-9-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-11-50
24c. NAME OF CEMETERY OR CREMATORY: Corinth
24d. LOCATION (City, town, or county) (State): Foley, Mo.

DATE REC'D BY LOCAL REG.: 8-28-1950
REGISTRAR'S SIGNATURE: Emma B. Riddle 162
25. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Elsberry, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
SEP - 2 1950
DISTRICT HEALTH OFFICE No. 4
File No. _____

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 _____

Licensed Embalmer No. 4012

P. O. Address Elsberry, 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.