

FILED SEP 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29564

State File No.

0123
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BIRTH NO. 51026-50 REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 360

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gideon	
d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) BARBARA	b. (Middle) JEAN	c. (Last) LACEY	4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Sept. 7, 1950	9. AGE (In years last birthday) 9. MONTHS 9. DAYS 9. HOURS 9. MIN. 11
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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	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Buddy Lacey	13b. MOTHER'S MAIDEN NAME Drusilla Richardson	14. NAME OF HUSBAND OR WIFE
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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 Buddy Lacey	ADDRESS Gideon, Missouri
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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		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) shic colitis acute		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) unknown DUE TO (c) unknown		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. unknown		7640	

19a. DATE OF OPERATION now	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-17-, 1950, to 9-18-, 1950, that I last saw the deceased alive on 9-18, 1950, and that death occurred at 3:00 P m., from the causes and on the date stated above.

23a. SIGNATURE B. J. Macomber M.D.	(Degree or title) M.D.	23b. ADDRESS Poplar Bluff	23c. DATE SIGNED 9-18-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 20, 1950	24c. NAME OF CEMETERY OR CREMATORY Springville	24d. LOCATION (City, town, or county) (State) Springville Mo.
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DATE REC'D BY LOCAL REG. Sept 20 1950	REGISTRAR'S SIGNATURE Wm. H. Johnson	25. FUNERAL DIRECTOR'S SIGNATURE Lloyd M. Kussner	ADDRESS Spring Ark
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

SEP 26 1950

BUTLER CO. HEALTH CENTER

FILE No. 950-389

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 By me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Lloyd M. Russell

Licensed Embalmer No. 7509 Ark

P. O. Address Piggott, Ark

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.