

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

36812

FILED NOV 2 - 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. 277 PRIMARY REG. DIST. NO. 5949 Registrar's No. 46

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pike</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Pike</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Towne Sub</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bowling Green Rt 4</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u> | | d. STREET ADDRESS (If rural, give location) <u>0 8 2 0</u> | |

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|---|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Lucy</u> b. (Middle) <u>FRANCES</u> c. (Last) <u>WYERS</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 20 1953</u> | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | |
| 8. DATE OF BIRTH <u>Nov 24 1879</u> | | 9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>24</u> IF UNDER 2 HRS. Hours <u>0</u> Min. <u>0</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pike Co. Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |

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| 13a. FATHER'S NAME <u>Marion Griffith</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sarah Morris Miller Myers</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mar Vera Aruchon Bowling Green</u> | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mar Vera Aruchon Bowling Green</u> | |
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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 | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer Lung</u> | | DUPLICATE (b) <u>cancer of Breast</u> | | | | | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUPLICATE (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>170X</u> | | 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) | | 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 Aug 1953, to Oct 1953, that I last saw the deceased alive on Oct 7, 1953, and that death occurred at 7:20 p.m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>E. P. Hansen D.O.</u> | | 23b. ADDRESS <u>Frankford Mo.</u> | | 23c. DATE SIGNED <u>Oct 22 1953</u> | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Oct 29 1953</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Farmers</u> | |
| | | | | 24d. LOCATION (City, town, or county) (State) <u>Pike Co Mo</u> | |

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|--|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <u>10-26-53</u> | | REGISTRAR'S SIGNATURE <u>Bill Robinson</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Grace Bankhead Bowling Green Mo</u> | |
|--|--|--|--|---|--|

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed.....
Harold C. Kink

Licensed Embalmer No. 4597

P. O. Address Parsons, Iowa

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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