

STANDARD CERTIFICATE OF DEATH

State File No. 399331

BIRTH NO. _____ REG. DIST. NO. 276 PRIMARY REG. DIST. NO. 5945 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Wayne	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - N. Dixon		c. LENGTH OF STAY (in this place) 32 days	c. CITY OR TOWN Piedmont, Mo
d. FULL NAME OF HOSPITAL OR INSTITUTION Ferndale Nursing Home		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) BARBARA		a. (First)	b. (Middle)
		c. (Last) Lashley	4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 25, 1872
9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Henry Heid	13b. MOTHER'S MAIDEN NAME Sis Heuble	14. NAME OF HUSBAND OR WIFE John Lashley	
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. _____	17. INFORMANT'S SIGNATURE OR NAME Ferndale Nursing Home - St James	
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) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 0
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerosis about 6 years	DUE TO (c)		
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		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) 4201	
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 Oct. 22/1953, to Nov. 15/1953, that I last saw the deceased alive on Nov. 12/1953, and that death occurred at 8:15 A.M., from the causes and on the date stated above.			
23a. SIGNATURE C. V. Hammler, M.D.		23b. ADDRESS St. James, Mo	23c. DATE SIGNED 11-16-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried	24b. DATE 11-17-53	24c. NAME OF CEMETERY OR CREMATORY Ferndale Cemetery	24d. LOCATION (City, town, or county) (State) Madison Co. - Mo.
DATE REC'D BY LOCAL REG. 11-17-53	REGISTRAR'S SIGNATURE Ruth B. Powell	479-0	25. FUNERAL DIRECTOR'S SIGNATURE OR ADDRESS Oral E. Licklider - St James Mo

(Licensed Embalmer's Statement on Reverse Side)

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

LED NOV 24 1953

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 me Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Orrel E. Tichliel

Licensed Embalmer No. 354

P. O. Address St. James

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.