

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43549

State File No. ....

FILED JAN 12 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 385 PRIMARY REG. DIST. NO. 3039 Registrar's No. 599

1. PLACE OF DEATH a. COUNTY LINN		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE MISSOURI b. COUNTY CHARITON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MARCELINE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MENDON	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		d. STREET ADDRESS (If rural, give location) NONE	
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) BOWERS c. (Last) LUCAS M.D.		4. DATE OF DEATH (Month) (Day) (Year) 12 14 53	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 7, 1856
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.D. PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY PRACTICE MEDICINE	9. AGE (In years last birthday) 97
11. BIRTHPLACE (State or foreign country) SALINE COUNTY, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN R. LUCAS		13b. MOTHER'S MAIDEN NAME SALLIE GUINN	14. NAME OF HUSBAND OR WIFE ADA M. LUCAS
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 ADDRESS JOHN H. LUCAS M.D. BROOKFIELD MISSOURI
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) UREMIA  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) SENILITY  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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 DEC 7, 1953, to DEC 14, 1953, that I last saw the deceased alive on DEC. 14, 1953, and that death occurred at 7:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE Paul T. Berry (Degree or title) M.D.		23b. ADDRESS Marceline Mo	23c. DATE SIGNED 12-14-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-17-53	24c. NAME OF CEMETERY OR CREMATORY Newcomer
24d. LOCATION (City, town, or county) (State) Mendon Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS S. J. Shepard Mendon Mo	
DATE REC'D BY LOCAL REG. 12-14-53		REGISTRAR'S SIGNATURE 401-0	

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 24 1954

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.....

*S. L. Lipard*

Licensed Embalmer No. ....

3970

P. O. Address.....

*Mendon 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.