

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

State File No.

15

No. 300
10.48
FILED JAN 21 1954

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville</u>	
c. LENGTH OF STAY (In this place) <u>5 weeks</u>		d. STREET ADDRESS (If rural, give location) <u>0013</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Florence</u>	b. (Middle) <u>Euretha</u>	c. (Last) <u>Mock</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 10 1954</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 5 1919</u>	9. AGE (In years last birthday) <u>34</u>	if UNDER 1 YEAR Months <u>9</u> Days <u>5</u>	if UNDER 24 HRS. Hour <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Factory Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Samual D. Hays</u>	13b. MOTHER'S MAIDEN NAME <u>Matilda Bradley</u>	14. NAME OF HUSBAND OR WIFE <u>Leo Dean Mock</u>
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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 <u>Leo Dean Mock</u>	ADDRESS <u>Elmer Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>metastasis of epidermoid carcinoma of cervix</u>		<u>1950</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>-</u> DUE TO (c) <u>-</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>secondary anemia and profound uremia</u>	<u>2 months</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION. <u>uremia</u> <u>171X</u>	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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 12-5-53, 1953, to 1-10, 1954, that I last saw the deceased alive on 1-10-54, 1954, and that death occurred at 1:47Am., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul Laughlin Jr.</u>	(Degree or title) <u>D. O. S.</u>	23b. ADDRESS <u>Kirksville, Mo.</u>	23c. DATE SIGNED <u>1-11-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 14 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St Carrel</u>	24d. LOCATION (City, town, or county) (State) <u>Adair Co Mo</u>
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DATE REC'D BY LOCAL REG. <u>1-13-54</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. McCall</u>	ADDRESS <u>South Gifford Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

APR 23 1967

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 *Wm McCallister*

Licensed Embalmer No. South Gifford 2052

P. O. Address South Gifford Vt

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.