

STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **314** PRIMARY REG. DIST. NO. **6064** Registrar's No. **33**

0930
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1. PLACE OF DEATH a. COUNTY St Clair		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY St Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Osceola rural		c. CITY OR TOWN Osceola	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) 19 yrs		e. STREET ADDRESS (If rural, give location) Osceola Township	
d. FULL NAME OF HOSPITAL OR INSTITUTION Waites Rest Home			

3. NAME OF DECEASED (Type or Print) a. (First) Martin b. (Middle) _____ c. (Last) Lacey			4. DATE OF DEATH (Month) (Day) (Year) 7 28 54		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec. 29, 1869	9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months 6 Days 29 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Martin Van Lacey	13b. MOTHER'S MAIDEN NAME Mary Ann Jennings	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk	16. SOCIAL SECURITY NO. Unk	17. INFORMANT'S SIGNATURE OR NAME Rest Home Records	ADDRESS Osceola, Mo
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) malignancy of throat		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) was insane - never		
	DUE TO (c) stroke.		
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 148x	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)
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 **July 1, 1954**, to **July 28, 1954**, that I last saw the deceased alive on **July 21, 1954**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Ruth Seewers M.D.	(Degree or title) (City, town, or county) (State) Osceola - Mo	23b. ADDRESS	23c. DATE SIGNED 7-28-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-29-54	24c. NAME OF CEMETERY OR CREMATORY Osceola Cemetery	24d. LOCATION (City, town, or county) (State) Osceola Missouri
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DATE REC'D BY LOCAL REG. 7-28-54	REGISTRAR'S SIGNATURE Ruth Seewers	25. FUNERAL DIRECTOR'S SIGNATURE T.B. Foodrich	ADDRESS Osceola, Mo.
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Rex Miller*.....

Licensed Embalmer No. *H.H.*

P. O. Address *Oscarola*

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.