

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41660**

FILED DEC 20 1954

BIRTH NO. _____ REG. DIST. NO. **195** PRIMARY REG. DIST. NO. **5708** Registrar's No. **102-~~5~~**

1. PLACE OF DEATH a. COUNTY McDonald		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY McDonald	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Goodman Rt. 1 Buffalo		c. LENGTH OF STAY (in this place) Life	c. CITY OR TOWN Goodman Rt. 1
d. FULL NAME OF HOSPITAL OR INSTITUTION KXXXX		e. STREET ADDRESS (If rural, give location) 7 miles west of Goodman, Mo	

3. NAME OF DECEASED (Type or Print) Lyman	a. (First)	b. (Middle) (none)	c. (Last) Devine	4. DATE OF DEATH (Month) (Day) (Year) December 8, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 21-1884	9. AGE (In years last birthday) 70	10. UNDER 1 YEAR 10	11. UNDER 1 HRS. Hours Min. 17
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and State or Foreign Country) McDonald Co. Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Samuel J. Devine	13b. MOTHER'S MAIDEN NAME Mary Dobbs	14. NAME OF HUSBAND OR WIFE Minerva Devine
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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) no	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME C. L. Devine Rt. 1, Goodman Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH Sudden
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 4201	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 type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1:15 A.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm. Humphrey Jr. Coroner	23b. ADDRESS Noel, Mo.	23c. DATE SIGNED 12-9-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 10-1954	24c. NAME OF CEMETERY OR CREMATORY Howard Cemetery	24d. LOCATION (City, town, or county) (State) Goodman, McDonald Mo.
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DATE REC'D BY LOCAL REG. 12-15-54	REGISTRAR'S SIGNATURE Mayme Humphrey	423	25 FUNERAL DIRECTOR'S SIGNATURE Robb Funeral Home Goodman Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEC 21

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 *Carl Rapp*

Licensed Embalmer No. *23458*

P. O. Address *Anderson, N.J.*

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.