

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27464

STATE FILE NUMBER

FILED SEP 12 1956

Registration District No. 170 Primary Registration District No. 5630 Registrar's No. 152

Health, Welfare  
Public Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Wyoming</b> b. COUNTY <b>Natrona</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>6 Miles E of Lebanon, Mo.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Casper</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Highway #66</b> Length of stay in 1b		d. STREET ADDRESS <b>518 N. McKinley St</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Earl</b> Last <b>Farley</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1938</b>
9. AGE (In years last birthday) <b>18</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>	11. BIRTHPLACE (City and state or country) <b>Basin, Wyoming</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Deceased</b>		14. MOTHER'S MAIDEN NAME <b>Maryallen Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes Jun 7, 1956 to present</b>		16. SOCIAL SECURITY NO. <b>17-111-11111</b>	
17. <b>MILLIGAN</b>		Address <b>US Army Hospital Ft. Leonard Wood</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intra-abdominal hemorrhage</b> DUE TO (b) <b>Ruptured spleen</b> DUE TO (c) <b>Automobile accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>		
20c. TIME OF INJURY <b>8:05</b> Hour <b>XXX</b> Month <b>Aug</b> Day <b>31</b> Year <b>56</b> p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, store, office bldg., etc.) <b>Highway #66</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>6 Miles E of Lebanon Mo. Laclede Co Mo.</b>	
21. I <b>James B. White</b> declare the deceased <b>Earl</b> died on <b>Sept 1, 1956</b> at <b>Highway #66</b> Death occurred at <b>8:05</b> P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James B. White, Capt. MC</b> <b>James B. White, Capt. MC</b>		22b. ADDRESS <b>US Army Hospital Ft Wood Mo</b>	22c. DATE SIGNED <b>9/1/56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Sept 1 56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Basin Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Basin Wyoming</b>
24. FUNERAL DIRECTOR <b>Hedges Funeral Homes Inc Crocker</b>		25. DATE RECD. BY LOCAL REG. <b>Mo 9-1-1956</b>	26. REGISTRAR'S SIGNATURE <b>Willa L. Hlay</b>

(Licensed Embalmer's Statement on Reverse Side)

Received 9-10-56  
Laclede County Health Unit  
File No. 152  
Date Filed 9-10-56

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 Clarence Gross

Licensed Embalmer No. 48

P. O. Address Waynesville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.