

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29717

STATE FILE NUMBER

FILED OCT 10 1958

Registration District No. 1 Primary Registration District No. 4001 Registrar's No. 300

|  |                       |   |  |   |   |
|--|-----------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY Adair   |                       |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo b. COUNTY Adair |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Novinger  |                       | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN Novinger   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION at home   |                       | Length of stay in 1b<br>1 yr  | d. STREET ADDRESS R. F. D. #2  |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Velma Rose Mc Claid  |                       |   | 4. DATE OF DEATH<br>Month Day Year<br>Sept. 29, 1956   |   |   |
| 5. SEX<br>F  | 6. COLOR OR RACE<br>W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>May 16, 1905   | 9. AGE (In years last birthday)<br>51   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Home  |                       | 10b. KIND OF BUSINESS OR INDUSTRY<br>Home   | 11. BIRTHPLACE (City and state or country)<br>Yukon, Oklahoma  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 13. FATHER'S NAME<br>Drury Lawson  |                       |   | 14. MOTHER'S MAIDEN NAME<br>Rosetta Low  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No X   |                       | 16. SOCIAL SECURITY NO.<br>484 18 3092  | 17. INFORMANT<br>Address<br>Sherman Mc Claid, New Lisbon, Wis.   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause definite for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of Lung   |                       |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |                       |   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                       |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input 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.)  |  |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m.<br>p. m.   |                       |   |  |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                       | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION   |   | COUNTY STATE  |
| 21. I attended the deceased from July to Sept 29-56 and last saw her alive on Sept 28-56<br>Death occurred at 7:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated. |                       |   |  |   |   |
| 22a. SIGNATURE<br>H. H. Garrison   |                       |   | 22b. ADDRESS<br>Novinger, Mo.  |   | 22c. DATE SIGNED<br>10/2/56   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                       | 23b. DATE<br>10/1/56  | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Cemetery  |   | 23d. LOCATION (City, town, or county) (State)<br>Kirksville, Mo.                                  |
| 24. FUNERAL DIRECTOR<br>Paul M. [Signature]  |                       | ADDRESS<br>Kirksville, Mo.  |  | 25. DATE RECD. BY LOCAL REG.<br>10-3-56 | 26. REGISTRAR'S SIGNATURE<br>Kate Lambert   |

(Licensed Embalmer's Statement on Reverse Side)

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

Health, Welfare Public Service

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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 *George W. Davalt*

Licensed Embalmer No. *479*

P. O. Address *Kirksville*

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