

FILED MAY 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 01 7772

STATE FILE NUMBER

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Odessa			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Odessa		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b 20 Yrs.	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lois Proctor Helm				4. DATE OF DEATH May 12, 1957		5. SEX Fe	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1911		9. AGE (In years last birthday) 45 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Johnson Co., Mo.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lloyd Helm				14. MOTHER'S MAIDEN NAME Vena Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Lloyd Helm, Odessa, Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 2 Pulmonary Infarct. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial DUE TO (c) Emboli							INTERVAL BETWEEN ONSET AND DEATH
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? YES <input checked="" type="checkbox"/> NO <input 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 Hour _____ a. m. _____ 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 March 20-57 to May 12-57 and last saw her alive on May 12-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) J. W. Martin M.D.				22b. ADDRESS Odessa, Mo.		22c. DATE SIGNED 5-15-57	
23a. BURIAL, CREMATION, BENEFICIAL SOCIETY Burial		23b. DATE May 14, 1957	23c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery		23d. LOCATION (City, town, or county) (State) Odessa, Mo.		
24. FUNERAL DIRECTOR Husman-Sparks ADDRESS Odessa, Mo.			25. DATE RECD. BY LOCAL REG. 5/15/1957		26. REGISTRAR'S SIGNATURE Emmuel Davidson		

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 causally related. Coroner cannot certify to a death due to natural causes.

(Licensed Embalmer's Statement on Reverse Side)

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 *William T. Gray*

Licensed Embalmer No. *44*

P. O. Address *Des Moines*

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.