

Health,
Welfare
Public
Service

300
1-56

Director, 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 6 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5700 179330

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY <u>MARION</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>HANNIBAL</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			c. CITY OR TOWN <u>CLARENCE MO</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			d. STREET ADDRESS (If outside, give location) <u>CLARENCE MO</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) Length of stay in lb <u>BERTHA BELL LOWERY</u> <u>10 DAYS</u>				4. DATE OF DEATH <u>MAY 29 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 17 1872</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		100. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (City and state or country) <u>MACON COUNTY MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>WILLIAM WHITCOMB</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE WILMAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS BRYAN SLATER CLARENCE MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardio-vascular Renal Disease (Arterio-sclerosis)</u> DUE TO (c) <u>Cardio-vascular</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
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? <u>0</u> 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 Hour <u>4:20</u> Month <u>2</u> Day <u>28</u> Year <u>57</u> a. m. <u>PM</u>							
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 <u>May 1 57</u> , to <u>May 29 57</u> and last saw her/him alive on <u>May 24 57</u> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>B. A. ...</u> (Degree or title)				22b. ADDRESS <u>...</u>		22c. DATE SIGNED <u>5-31-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5-31-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE WOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>	
24. FUNERAL DIRECTOR <u>Chas V. Greening</u> ADDRESS <u>Clarence Mo</u>				25. DATE RECD. BY LOCAL REG. <u>6-1-57</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke By W. J. ...</u>	

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED

JUN 4 1957

MARION CO. HEALTH DEPT.

DATE FILED

JUN 4 1957

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 *Charles V. Meacham*

Licensed Embalmer No. *460*

P. O. Address *Clare*

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.