

Health, Welfare, Public Service

FILED AUG 22 1957

STANDARD CERTIFICATE OF DEATH

57 0 276 19 STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 493

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wayne</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <b>Poplar Bluff</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Williamsville</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>Doctors Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>RR # 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>LUKE</b> Last <b>LUKE</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>9,</b> Year <b>1957</b>		
---	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-21-1908</b>	9. AGE (In years, months, days) <b>49</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-----------------------	----------------------------------	---	--------------------------------------	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Station Agent</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>MoPac Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Williamsville, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	--	---	--

13a. FATHER'S NAME <b>Mason Luke</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Durrow</b>	14. NAME OF HUSBAND OR WIFE <b>Virginia Smith</b>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>498-10-2217</b>	17. INFORMANT Address <b>Mrs. Virginia Luke, Williamsville, Mo.</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>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b): <b>Multiple Rib. Fractures</b>	<b>2 months</b>
	DUE TO (c): <b>Multiple Myeloma</b>	<b>2 yrs</b>
PART II.: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - <b>203X</b>		19. WAS AUTOPSY PERFORMED? 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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <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 <b>7-29-57</b> to <b>8-9-57</b> and last saw her alive on <b>8-9-57</b> Death occurred at <b>10:30 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <b>Marion R. Barbouy MD</b> (Degree or title)	22b. ADDRESS <b>Poplar Bluff, Mo.</b>	22c. DATE SIGNED <b>8/11/57</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-12-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Military Crossing</b>	23d. LOCATION (City, town, or county) (State) <b>Wayne County, Mo.</b>
--	-------------------------------	--	---

24. FUNERAL DIRECTOR <b>Greer Croy &amp; Fitch, Poplar Bluff, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8/14/57</b>	26. REGISTRAR'S SIGNATURE <b>By [Signature]</b>
--	---------	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

39

RECEIVED  
AUG 19 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 Ray J. Adams

Licensed Embalmer No. 4928

P. O. Address Springfield, Ill.

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.