

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31556

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>HARRISON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BETHANY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Albany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NOLL MEMORIAL</u>			Length of stay in 1b <u>90 days</u>		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) First <u>Victor</u> Middle <u>Reuben</u> Last <u>SEARCY</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>29</u> Year <u>1957</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20 1905</u>		9. AGE (In years last birthday) <u>52</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Gentry County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Rueben F. Searcy</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Adeline Jones</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.		17. INFORMANT Address <u>Mrs James Green Albany, 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>ARTERIOCLAR NEPHROSCLEROSIS</u> DUE TO (b) <u>CHRONIC HYPERTENSION</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CARDIAC INSUFFICIENCY</u>								INTERVAL BETWEEN ONSET AND DEATH <u>over 3 mo.</u> <u>over 10 yrs.</u>	
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. Month _____ Day _____ Year _____									
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>July 2, 1957</u> to <u>SEPT. 29, 1957</u> and last saw ^{her} him alive on <u>SEPT. 29, 1957</u> Death occurred at <u>1:15 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Albert Tubbe M.D.</u>				22b. ADDRESS <u>Box 33 Bethany, Mo.</u>				22c. DATE SIGNED <u>9-30-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Oct 1, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wayman</u>		23d. LOCATION (City, town, or county) <u>Gentry Co.</u>		STATE <u>Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Clifford Brooks Albany, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Oct 6-57</u>		26. REGISTRAR'S SIGNATURE <u>Gella Maxey</u>			

(Licensed Embalmer's Statement on Reverse Side)

OCT 17 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 me Student Embalmer No. working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Donald E. Cochell

Licensed Embalmer No. 48

P. O. Address Albany, N. Y.

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.