

FILED OCT 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34722

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. 4014 Registrar's No. 94

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Atchison</u>				a. STATE <u>Iowa</u>		b. COUNTY <u>Potta</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Oakland</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>Fairfax Hospital</u>			Length of stay in lb <u>12 days</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. MONTH DAY YEAR	
First Middle Last <u>La Vonne Ann Minick</u>				<u>Oct 5, 1957</u>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<u>female</u>	<u>white</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>June 16, 1922</u>		<u>35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>			<u>own home</u>	<u>Oakland, Iowa.</u>		<u>U.S</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Glenn Gillespie</u>				<u>Stella Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
<u>no</u>		<u>none</u>		<u>Delbert Minick</u>		<u>Fairfax, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u>							<u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							<u>14 days</u>
DUE TO (b) <u>Ingestion of Chlorpromazine, 800 mg</u>							
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? 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 Month, Day, Year 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.) <u>9-26-57</u>		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>9-26-57</u> to <u>10-5-57</u> and last saw her <u>him</u> alive on <u>10-5-57</u> Death occurred at <u>5:25 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James R. Allan M.D.</u>				22b. ADDRESS <u>Rock Port, Mo.</u>		22c. DATE SIGNED <u>10/6/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>removal</u>		<u>10/6/57</u>	<u>Oakland, Iowa.</u>		<u>Oakland, Iowa.</u>		
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
<u>Davis Funeral Home Tarkio, Mo.</u>				<u>10/16/1957</u>		<u>Thermin J. Schoeler</u>	

(Licensed Embalmer's Statement on Reverse Side)

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uses 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

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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 *Frost A. Brown*

Licensed Embalmer No. 333

P. O. Address Parkio, Mo.

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.