Health, Welfare Public Service

300 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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34839 STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1151

1. PLACE OF DEATH
a. COUNTY BUCHANAN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. METHODIST Hosp — Length of stay in 1b 5 days.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY GENTRY
c. CITY OR TOWN DARLINGTON — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS 6 miles S.W. (If outside, give location) — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First LAWRENCE Middle ERNEST Last ANGLE

4. DATE OF DEATH Month Oct. Day 18 Year 1957

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MARCH 24, 1895
9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (City and state or country) KING CITY MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME NELSON ANGLE
14. MOTHER'S MAIDEN NAME MINNIE BONHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT Address MRS. LETAH E. ANGLE, DARLINGTON MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 4 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Lobar pneumonia — 6 days
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 490X
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10-14-57, to 10-18-57 and last saw her/him alive on 10-18-57
Death occurred at 1:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. H. Ryan M.D.
22b. ADDRESS St. Joseph Mo.
22c. DATE SIGNED 10.23.57

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE Oct 19, 1957
23c. NAME OF CEMETERY OR CREMATORY HIGH RIDGE
23d. LOCATION (City, town, or county) STANBERRY (State) MO.

24. FUNERAL DIRECTOR Johnson Funeral Home Stanberry Mo. ADDRESS
25. DATE RECD. BY LOCAL REG. Oct. 29, 1957
26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

(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 en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Albert D. Harrington

Licensed Embalmer No: 32

P. O. Address St. Jose

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.