

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED NOV 19 1957

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 76Health,
& Welfare
Public
Service300
1-57

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mercer</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Versailles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Princeton</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>Kidwell Rest Home 3 Yrs</u>		Length of stay in 1b	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>Arch</u> Middle <u>Morris</u> Last <u>Lindsey</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</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 type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28, 1864</u>	9. AGE (In years of birthday) <u>92</u>	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)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Princeton, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u>	
13a. FATHER'S NAME <u>Archabald Lindsey</u>		13b. MOTHER'S MAIDEN NAME <u>Matha Woods</u>		14. NAME OF HUSBAND OR WIFE <u>Josephine Hook</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Mrs Lovell Thickett Sunrise Beach</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>gastric hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>etiology unknown</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) <u>advanced arteriosclerosis 4500</u>				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 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>Sept. 1957</u> to <u>Nov 9 1957</u> and last saw ^{her} _{him} alive on <u>Nov 9 1957</u> Death occurred at <u>11 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Jack Gunnard</u> (Pegged or Stile)			22b. ADDRESS <u>Versailles, Mo.</u>		22c. DATE SIGNED <u>Nov 9, 1957</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10 Nov. 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Princeton Masonic Cem. Princeton, Mo.</u>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR <u>W. F. Kidwell Versailles, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-9-57</u>	26. REGISTRAR'S SIGNATURE <u>J L Wall</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

NOV 20 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 *Raymond C. Barber*

Licensed Embalmer No. *4626*

P. O. Address *Wesley, Mo*

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.