

FILED JAN 6 1958

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **45000**

BIRTH NO. _____ REG. DIST. NO. **385** PRIMARY REG. DIST. NO. **3039** Registrar's No. **288**

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Linn	
b. CITY OR TOWN Marceline	c. LENGTH OF STAY (in this place) 14 da	c. CITY OR TOWN Marceline	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		e. STREET ADDRESS (If rural, give location) 215 W Walker	

3. NAME OF DECEASED (Type or Print) a. (First) Luvella b. (Middle) _____ c. (Last) King			4. DATE OF DEATH (Month) (Day) (Year) 12 26 57		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 4/12/1890		9. AGE (In years last birthday) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) D Macon, Co.		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME J.S. Franks		13b. MOTHER'S MAIDEN NAME Laura Payton		14. NAME OF HUSBAND OR WIFE Minor King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs Thelma Brailey Marceline, Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Central Thrombotic Progression		2	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arteriosclerosis			
		DUE TO (b)			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? D YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 332X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **12-12, 1957**, to **12-26, 1957**, that I last saw the deceased alive on _____, 19____, and that death occurred at **3:25 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Robert W. Owens M.D.		23b. ADDRESS Marceline, Mo		23c. DATE SIGNED 12-27-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) R		24b. DATE 12/28/57		24c. NAME OF CEMETERY OR CREMATORY Hull	
		24d. LOCATION (City, town, or county) (State) Callao, Mo			

DATE REC'D BY LOCAL REG. 12-28-57		REGISTRAR'S SIGNATURE Broudie Owens		25. FUNERAL DIRECTOR'S SIGNATURE James M. Laughlin	
				ADDRESS Marceline, Mo	

(Licensed Embellisher's Stamp on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Jamer B. McClelland*

Licensed Embalmer No. *4130*

P. O. Address *Brookfield*

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.