

FILED DEC 30 1957

STANDARD CERTIFICATE OF DEATH

45329
STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 144

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LOUISIANA</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP.</u>		Length of stay in lb <u>19 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>R.F.D. ONE</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>VEVE - CLAPP</u>			4. DATE OF DEATH Month Day Year <u>Dec 21 1957</u>
5. SEX <u>FEMALE</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>Nov. 27, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>KEOKUK, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>WILLIAM F. FORKER</u>		13b. MOTHER'S MAIDEN NAME <u>SADIE VEVE SELMAN</u>	14. NAME OF HUSBAND OR WIFE <u>CHESTER E. CLAPP</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. <u>NONE</u>	17. INFORMANT Address <u>MISS RUTH RAYMOND - AMES, IOWA</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>Cerebrovascular accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Hypertension Cardiac</u>			DUE TO (c) <u>443XF</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of hip 3/7/57 - Iridocyclitis of right eye</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>fell at home</u>		20c. TIME OF INJURY Hour a.m. <u>3/1/57</u> p.m. <u>X</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Louisiana, Pike Mo.</u>
21. I attended the deceased from <u>1952</u> to <u>12/21/57</u> and last saw her alive on <u>12/21/57</u> Death occurred at <u>9:05</u> P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Chas. H. Livellen M.D.</u>		22b. ADDRESS <u>Louisiana, Mo.</u>	22c. DATE SIGNED <u>12/21/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>DEC. 23, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BURLINGTON, IOWA</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS <u>GEO. M. COLLIER, LOUISIANA</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 21 1957</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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OCT 8 1958

MAY 16 1958

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 *Geo. M. Callier*

Licensed Embalmer No. *3839*
P. O. Address *Louisiana*

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.