

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013241

STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 207

800
-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Warren</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sunnyside</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>Boone County Hosp.</u>		Length of stay in 1b <u>1 day</u>	d. STREET ADDRESS <u>Rt. #1</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Wilson</u> Last <u>Lothridge</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc 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>JAN. 12, 1885</u>	9. AGE (In years last birthday) <u>73</u>	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Lothridge</u>		13b. MOTHER'S MAIDEN NAME <u>Lucinda Hendricks</u>		14. NAME OF HUSBAND OR WIFE <u>Martha Classill</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>400-52-7634</u>		17. INFORMANT Address <u>Boone County Hosp Records, Columbia, Mo</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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u>443X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>Unknown</u>
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 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>5-5-58</u> to <u>5-6-58</u> and last saw ^{him} alive on <u>5-5-58</u> Death occurred at <u>2:00 a.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>Charles M. Faulke, M.D.</u>			22b. ADDRESS <u>Columbia, Missouri</u>		22c. DATE SIGNED <u>5-6-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>May 6, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reed's Cem Warren Co. Ky</u>		23d. LOCATION (City, town, or county) (State) <u>Bowling Green, Kentucky</u>
24. FUNERAL DIRECTOR <u>Parker Funeral Service, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>May 6 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *George R. Kufy*

Licensed Embalmer No. *4752*

P. O. Address *Columbia, S.C.*

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.