

r. Health,
& Welfare
Public
Service
S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027997
STATE FILE NUMBER

FILED JUL 29 1958 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 108

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| 1. PLACE OF DEATH a. COUNTY Vernon | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Camden | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Climax Springs, Mo. | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 3 | Length of stay in 1b 20 yrs., 3 days | d. STREET ADDRESS unknown | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Leoda Middle Larimore Last Larimore | 4. DATE OF DEATH Month July Day 11 Year 1958 |
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|----------------------|-------------------------------|---|----------------------------------|---|--|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-3-1893 | 9. AGE (In years last birthday) 64 years | IF UNDER 1 YEAR Months 0 Days 8 | IF UNDER 24 HRS. Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Camden County, Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME J. S. Daniels | 13b. MOTHER'S MAIDEN NAME Rebecca Crawford | 14. NAME OF HUSBAND OR WIFE Sam Larimore (Deceased) |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Address Admission papers, State Hospital # 3 |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vessel Disease | | INTERVAL BETWEEN ONSET AND DEATH years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Status epilepticus | one day |
| | DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3532 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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. _____ | |

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| 20d. INJURY OCCURRED WHILE AT <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 |
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21. I attended the deceased from **April 25, 1955**, to **July 11, 1958** and last saw **her** alive on **July 11, 1958**
Death occurred at **3:45 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) E. Allen Pickens, M.D. | 22b. ADDRESS Nevada, Missouri | 22c. DATE SIGNED 7-11-58 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 13, 1958 | 23c. NAME OF CEMETERY OR CREMATORY St. Lenix Springs Catholic Cemetery, St. Louis, Mo. | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
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| 24. FUNERAL DIRECTOR John F. Reun Warsaw, Mo | 25. DATE REC'D. BY LOCAL REG. 7-22-1958 | 26. REGISTRAR'S SIGNATURE Armed E. Ferry |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed.

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 *John F. Pleser*

Licensed Embalmer No. *4098*

P. O. Address *Warsaw*

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.