

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032442
STATE FILE NUMBER

FILED OCT 6 1958 Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 128

S. 300
1-57

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Harrison</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Bethany</u> c 411 c |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u> | | Length of stay in 1b <u>2 mo.</u> | d. STREET ADDRESS (If outside, give location) <u>716th St</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>James W. Lacy</u> | | | 4. DATE OF DEATH Month Day Year <u>9-30-1958</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-27-1905</u> |
| 9. AGE (In years last birthday) <u>53</u> | | IF UNDER 1 YEAR Months Days <u>6 3</u> | IF UNDER 24 HRS. Hours Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Rest Home</u> | 11. BIRTHPLACE (City and state or country) <u>Coleridge Neb.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13a. FATHER'S NAME <u>James W. Lacy</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Margaret Caharty</u> | | 14. NAME OF HUSBAND OR WIFE <u>Dolynne Lacy</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>491-22-5680</u> | 17. INFORMANT Address <u>Dolynne Lacy Bethany 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>Suicide</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Shot self in mouth with 22 gauge rifle</u> DUE TO (c) <u>976X</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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. <u>1 p.m.</u> <u>9-30-58</u> | | 20d. INJURY OCCURRED WHILE AT <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>at home 716th St</u> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Bethany Harrison Mo</u> | |
| 21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at <u>10-2-58-1p</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Ernest L. Groves D.D.</u> | | 22b. ADDRESS <u>Bethany, Mo.</u> | 22c. DATE SIGNED <u>10-2-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u> | 23b. DATE <u>10-2-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ridgeway</u> | 23d. LOCATION (City, town, or county) (State) <u>Ridgeway Mo.</u> |
| 24. FUNERAL DIRECTOR <u>M. B. Haas</u> | | ADDRESS <u>Bethany Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>10-2-58</u> |
| 26. REGISTRAR'S SIGNATURE <u>Zella Masey</u> | | | |

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.

OCT 8 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 *MSH*

Licensed Embalmer No. *3899*

P. O. Address *Bethany, 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.