

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035814

STATE FILE NUMBER

FILED NOV 6 1958

Registration District No. 73

Primary Registration District No. 4132

Registrar's No. 152

S. 300
y. 1-57

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holt</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Concord Township</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	Length of stay in 1b <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>025^c</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Hugh</u> Last <u>Bernard</u>			4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 10, 1881</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____

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>X X</u>	11. BIRTHPLACE (City and state or country) <u>Rogersville, Tennessee</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Samuel Bernard</u>	13b. MOTHER'S MAIDEN NAME <u>Leanna Ball</u>	14. NAME OF HUSBAND OR WIFE <u>Addie Bernard</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>X X X X</u>	16. SOCIAL SECURITY NO. <u>X X</u>	17. INFORMANT <u>Coy Bernard, Plattsburg, Missouri</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>Transition following acute obstruction of the colon - probably diverticulitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized & cerebral & cardiovascular arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	---

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input checked="" 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. _____	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 _____
---	---------------------------------------	--------------------------

21. I attended the deceased from <u>April, 1958</u> to <u>Oct., 1958</u> and last saw him <u>live on Oct. 16, 1958</u> Death occurred at <u>4 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr Luckenbill MD</u> (Degree or title)	22b. ADDRESS <u>Plattsburg, Mo.</u>	22c. DATE SIGNED <u>10-20-58</u>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 21, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Plattsburg, Missouri</u>
--	----------------------------------	---	---

24. FUNERAL DIRECTOR <u>Lyon Funeral Home Inc. Plattsburg, Mo.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>Nov 1-1958</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Graham</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

91. 0



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 *Philip E. Cox*

Licensed Embalmer No. *PH 993*
P. O. Address *Hamlet, 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.