Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008101
STATE FILE NUMBER

FILED FEB 17 1959 Registration District No. 336 Primary Registration District No. 4493 Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY Shannon
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Birch Tree — Inside Limits Yes # No
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Shannon
c. CITY OR TOWN Birch Tree — Inside Limits Yes # No
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First WILLIAM Middle Columbus Last LAYMAN

4. DATE OF DEATH Month Jan. Day 22, Year 1959

5. SEX M
6. COLOR OR RACE W
7. MARRIED # NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH Feb. 1, 1872
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Lebanon, Missouri
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Joseph Layman
13b. MOTHER'S MAIDEN NAME Sarah C. Williams
14. NAME OF HUSBAND OR WIFE Lena Layman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Lena Layman Address Birch Tree, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 5 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X
19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
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 12/24/55, to 12/28/55 and last saw him alive on 12/28/55
Death occurred at 5:50 A M on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. Callahan M.D. (Degree or title)
22b. ADDRESS West Plains, Mo
22c. DATE SIGNED 2-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-25-59
23c. NAME OF CEMETERY OR CREMATORY Bethleham
23d. LOCATION (City, town, or county) (State) Birch Tree, Mo.

24. FUNERAL DIRECTOR Duncan Funeral Home ADDRESS
25. DATE RECD. BY LOCAL REG. Feb 16, 1959
26. REGISTRAR'S SIGNATURE Mabel Rees

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Richard A. Norton

Licensed Embalmer No. 5029

P. O. Address Milton Vista

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.