

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013658

STATE FILE NUMBER

FILED MAY 12 1959 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 209

300
1-57

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1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Independence 7 00 E Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Rest Haven		Length of stay in lb 2 yrs	d. STREET ADDRESS (If outside, give location) 1504 Truman Road Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Lapworth Last Lapworth			4. DATE OF DEATH Month April Day 30 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1874
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Mondamin- Iowa
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME George Case	
13b. MOTHER'S MAIDEN NAME Sarah Thorne		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Izetta Darrington Council Bluff Iowa.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive PT pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Influenza DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 480X			INTERVAL BETWEEN ONSET AND DEATH 4 days 1 month
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) none		20c. TIME OF INJURY Hour _____ 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.) none	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Jan 22, '59 to May 1, '59 and last saw her/him alive on April 30, 1959 Death occurred at _____ m on the date stated above and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John P. Green M.D.		22b. ADDRESS Independence Mo 10901 Wanner Rd	22c. DATE SIGNED 5-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 1, 1959	23c. NAME OF CEMETERY OR CREMATORY Crescent	23d. LOCATION (City, town, or county) (State) Crescent - Iowa
24. FUNERAL DIRECTOR ADDRESS Roland R. Speaks Indep. Mo		25. DATE RECD. BY LOCAL REG. 5-1-59	26. REGISTRAR'S SIGNATURE James L. Lewis

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.

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 *Rollie Fessel*

Licensed Embalmer No. *4690*
P. O. Address *Indep. 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.