

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023582

FILED JUL 3 1959

Registration District No. 317

Primary Registration District No. 541

STATE FILE NUMBER 1735
Registrar's No.

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Clayton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Res. #32 Arundel Pl.		d. STREET ADDRESS (If outside, give location) 32 Arundel Place	
3. NAME OF DECEASED (Type or print) First LAVINIA Middle VARCOE Last DURE		4. DATE OF DEATH Month June Day 27 Year 1959	
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 June 3, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Kansas City, Missouri
13a. FATHER'S NAME John Frances Varcoe		13b. MOTHER'S MAIDEN NAME Lavinia Woodgate	14. NAME OF HUSBAND OR WIFE Gilbert C. Dure
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 Gilbert C. Dure, 32 Arundel Place
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 Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 13 days
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) 33ix			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input checked="" 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 June 18-59 to June 27-59 and last saw her alive on June 27-59 Death occurred at 7 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Louis Schuchert MD		22b. ADDRESS 3566 Pine Blain	
		22c. DATE SIGNED June 28	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 29, 1959	
23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, 6175 Delmar		25. DATE RECD. BY LOCAL REG. 6-29-59	
26. REGISTRAR'S SIGNATURE John C. Murphy MD			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. ~~W. Schuchat~~
Louis Schuchat
3866 Flossa (Side Entrance)
Pr 61410

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 E. McCallon*
Licensed Embalmer No. *2460*
P. O. Address *6175 Pl...*

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.