

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024413

FILED VS JUL 27 1959 3

Registration District No. 3009 Primary Registration District No. 262 Registrar's No.

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jackson</b>		Length of stay in 1b <b>5 years</b>		c. CITY OR TOWN <b>Jackson</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deal Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>914 Cape Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>LaCROIX</b> Last <b>LaCROIX</b>				4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/9/1877</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b>	IF UNDER 24 HR Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer, ret.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (City and state or country) <b>Columbia, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>
13a. FATHER'S NAME <b>Jacob LaCroix</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret Janson</b>			14. NAME OF HUSBAND OR WIFE <b>Ollie S. LaCroix</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>488-24-9708</b>		17. INFORMANT <b>Manford Schwab Jackson, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Heart Knaw</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <b>3:30</b> a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Jan-1958</b> to <b>July 19-59</b> and last saw him alive on <b>July 18-59</b> Death occurred at <b>3:30</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Manford Schwab</b> (Degree or title) <b>MB</b>				22b. ADDRESS <b>Jackson Mo</b>		22c. DATE SIGNED <b>7-21-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cape Girardeau, Missouri</b>		
24. FUNERAL DIRECTOR <b>Walther's Funeral Home</b>			ADDRESS <b>Cape Gir., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-22-59</b>	26. REGISTRAR'S SIGNATURE <b>Drew Kasten</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William Lee Town

Licensed Embalmer No. 24418

P. O. Address Cape Fear

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.