

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024528

FILED JUL 16 1959

Registration District No. _____ Primary Registration District No. 5287 Registrar's No. 61 STATE FILE NUMBER 61

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| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fishing River Twp.</u> Length of stay in 1b <u>2 weeks</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Dubuque</u> c. CITY OR TOWN <u>Dubuque</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>YMCA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mi. SW Excelsior Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>YMCA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Alan</u> Last <u>Sutton</u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-20-1927</u> | 9. AGE (last birthday) <u>32</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Train Dispatcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Milwaukee R.R.</u> | | 11. BIRTHPLACE (City and state or country) <u>Ottumwa, Iowa</u> | |
| 13a. FATHER'S NAME <u>Francis B. Sutton</u> | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Anderson</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</u> | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Korea</u> | 16. SOCIAL SECURITY NO. <u>722-18-8606</u> | 17. INFORMANT Address <u>F.B. Sutton, Rt. #2, Excelsior Springs, Mo.</u> |
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| 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>Bullet Wound Of Temple.</u> (German Luger pistol) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour _____ 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 |
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>D. S. Patton, M.D., Professor</u> | 22b. ADDRESS <u>North Kansas City, Mo.</u> | 22c. DATE SIGNED <u>6/29/59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7-1-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Lawson, Missouri</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u> | 25. DATE RECD. BY LOCAL REG. <u>7-4-59</u> | 26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u> |
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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 Ludley Jarm

Licensed Embalmer No. 458
P. O. Address Exelior

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