

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025807

FILED VS JUL 29 1959

Registration District No. _____ Primary Registration District No. 5655 Registrar's No. 82

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon	Length of stay in 1b 13 days	c. CITY OR TOWN Dunnegan	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.F.D.

3. NAME OF DECEASED (Type or print) First Lois Middle Mae Last Mauck			4. DATE OF DEATH Month July Day 19 Year 1959			
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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 8-27-22	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Kansas	11. BIRTHPLACE (City and state or country) Kansas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Thomas Boyd Clark	13b. MOTHER'S MAIDEN NAME Anna Bell Gibson	14. NAME OF HUSBAND OR WIFE Leonard R. Mauck
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT San.records, Mo. State Sanatorium	Address Mt. Vernon, Mo.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Chronic Cor Pulmonale		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary Insufficiency DUE TO (c) Pulmonary Tuberculosis, Far Advanced, Active		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Left thoracoplasty, old		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 **July 6, 1959** to **July 19, 1959** and last saw her **her** alive on **July 19, 1959**
 Death occurred at **3:43 p.m.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Lewis Gates, M.D.	22b. ADDRESS Mt. Vernon, Missouri	22c. DATE SIGNED 7-20-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-24-59	23c. NAME OF CEMETERY OR CREMATORY Sinking Creek	23d. LOCATION (City, town, or county) (State) Near Everton, Mo.
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24. JUDICIAL DIRECTOR J.W. Birch	ADDRESS Ash Grove, Mo.	25. DATE RECD. BY LOCAL REG. 7-24-59	26. REGISTRAR'S SIGNATURE Cecil Hendricks
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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 Richard E. Watts

Licensed Embalmer No. 4652
P. O. Address Oak Grove, Va

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