

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028076

FILED VS. SEP 14 1959 16

Registration District No. _____ Primary Registration District No. 3004 Registrar's No. 67

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Barton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Barton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lamar</u>			Length of stay in 1b <u>35 yrs</u>		c. CITY OR TOWN <u>Lamar</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>705 Poplar</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>206 Gulf</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MATILDA</u> Middle <u>ELIZABETH</u> Last <u>DUCKETT</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-1866</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (City and state or country) <u>St. Catherine, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13a. FATHER'S NAME <u>Perry H. Taylor</u>			13b. MOTHER'S MAIDEN NAME <u>Mary E. Allen</u>			14. NAME OF HUSBAND OR WIFE <u>Dr. T. H. Duckett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Ida Webb, Lamar, Mo.</u>			
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>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years -</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arterio sclerosis -</u>						<u>years</u>	
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 checked="" 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 _____ 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 <u>Sept. 1, 1958</u> to <u>Sept. 8, 1959</u> and last saw her <u>Sept. 9, 1959</u> alive on <u>Sept. 9, 1959</u> Death occurred at <u>12:47</u> p. m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Doctor or title) <u>Charles F. Sheel, M.D.</u>				22b. ADDRESS <u>Lamar, Mo.</u>		22c. DATE SIGNED <u>9/10/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Sept 10 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake</u>		23d. LOCATION (City, town, or county) <u>Lamar, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Konantz Funeral Home, Lamar, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>SEP 10 '59</u>		26. REGISTRAR'S SIGNATURE <u>Marie Konantz</u>		

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 Carl F. Konantz

Licensed Embalmer No. 2247

P. O. Address Lamar, Mo

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.