

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028551

FILED VS. AUG 24 1959

Primary Registration District No.

Registrar's No.

59-65

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Dade			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo			b. COUNTY Dade											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lockwood Mo		Length of stay in 1b Days		c. CITY OR TOWN Lockwood Mo rt.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Hospital			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5mi North			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Clarence			Middle O			Last Dwyer			4. DATE OF DEATH Month Aug			Day 15			Year 1959		
5. SEX Male		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 Aug 29 1888		9. AGE (last birthday) 70		IF UNDER 1 YEAR Months 11 Days 16 Hours Min. 		IF UNDER 24 HR Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (City and state or country) Kansas			12. CITIZEN OF WHAT COUNTRY usa								
13a. FATHER'S NAME John H Dwyer				13b. MOTHER'S MAIDEN NAME Jane Wiseman				14. NAME OF HUSBAND OR WIFE Flossie A Dwyer									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW #1				16. SOCIAL SECURITY NO. 196-12-7175		17. INFORMANT Flossie A Dwyer				Address Lockwood Mo rt							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure (uncontrolled) acute DUE TO (b) Chronic Congestive Heart failure DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pt. Developed Severe Cerebral Cause of Death								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 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 8-11-59 to 8-15-59 and last saw her ^{her} alive on 8-15-59 Death occurred at 7:45A m on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title) Elmer W Taylor M.D.						22b. ADDRESS Lockwood, Mo			22c. DATE SIGNED 8/18/59								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 18, 1959		23c. NAME OF CEMETERY OR CREMATORY Lockwood			23d. LOCATION (City, town, or county) Lockwood M.										
24. FUNERAL DIRECTOR Allison Funeral Home Greenfield Mo					ADDRESS		25. DATE RECD. BY LOCAL REG. 8/21/59		26. REGISTRAR'S SIGNATURE J. C. Canada								

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 25 1959

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 W.P. Allison

Licensed Embalmer No. 4404

P. O. Address Greenville

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.